Child/Adolescent Behavioral and Mental Health Study

This study was jointly funded by the Mary Black Foundation and its CONNECT program, the United Way of the Piedmont and the Spartanburg Public School System
ACKNOWLEDGEMENTS

This report was funded by three organizations—the Mary Black Foundation, the United Way of the Piedmont and the Spartanburg School District. A Steering Committee of thirty committed local mental and behavioral health professionals and advocates met monthly from April through August to process the individual findings from a variety of primary and secondary research sources derived by Germane Solutions. Their input and dedication to the children, adolescents and their families and caretakers in Spartanburg County, South Carolina are evident. We are grateful for their passion in serving this population.

<table>
<thead>
<tr>
<th>STEERING COMMITTEE MEMBER</th>
<th>ORGANIZATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alan Eggert</td>
<td>Spartanburg School System: District 6</td>
</tr>
<tr>
<td>Carey Rothschild</td>
<td>Spartanburg Regional Healthcare System</td>
</tr>
<tr>
<td>Cathy Sparks</td>
<td>EMERGE</td>
</tr>
<tr>
<td>Colin Bauer</td>
<td>Spartanburg School System: School District 7</td>
</tr>
<tr>
<td>Deb Foreman</td>
<td>PFLAG</td>
</tr>
<tr>
<td>Donald Mims</td>
<td>Spartanburg School System: School District 7</td>
</tr>
<tr>
<td>Heather Witt</td>
<td>United Way of the Piedmont</td>
</tr>
<tr>
<td>Jameson Smith</td>
<td>The Forrester Center</td>
</tr>
<tr>
<td>Jennifer Parker</td>
<td>University of South Carolina Upstate</td>
</tr>
<tr>
<td>Jessica Hamlet</td>
<td>ReGenesis Healthcare</td>
</tr>
<tr>
<td>Josie Jones</td>
<td>South Carolina Department of Social Services</td>
</tr>
<tr>
<td>Lance Feldman</td>
<td>Eastern Carolinas Group; Child Psychiatrist</td>
</tr>
<tr>
<td>Laura Barbas Rhoden</td>
<td>Hispanic Alliance</td>
</tr>
<tr>
<td>Lauren Hulstrand</td>
<td>Wofford College</td>
</tr>
<tr>
<td>Molly Talbot-Metz</td>
<td>Mary Black Foundation</td>
</tr>
<tr>
<td>Natalia Valenzuela-Swanson</td>
<td>Mary Black Foundation</td>
</tr>
<tr>
<td>Patty Nodine</td>
<td>ReGenesis Healthcare</td>
</tr>
<tr>
<td>PJ McEnroe</td>
<td>EMERGE</td>
</tr>
<tr>
<td>Polly Edwards-Padgett</td>
<td>Mary Black Foundation</td>
</tr>
<tr>
<td>Robyn Hussa Farrell</td>
<td>Mental Fitness</td>
</tr>
<tr>
<td>Roc Robinson</td>
<td>Spartanburg School System: School District 6</td>
</tr>
<tr>
<td>Roger Williams</td>
<td>South Carolina Department of Mental Health</td>
</tr>
<tr>
<td>Ruth Schoonover</td>
<td>Spartanburg School System: School District 3</td>
</tr>
<tr>
<td>Sabrina Richardson</td>
<td>Intrinsic Therapy, LLC</td>
</tr>
<tr>
<td>Sharyn Pittman</td>
<td>NAMI (National Alliance on Mental Illness) Spartanburg</td>
</tr>
<tr>
<td>Susan Richards</td>
<td>South Carolina Department of Juvenile Justice</td>
</tr>
<tr>
<td>Tom Barnet</td>
<td>Spartanburg County Behavioral Health Task Force</td>
</tr>
<tr>
<td>Trish Beason</td>
<td>Spartanburg School System: School District 1</td>
</tr>
<tr>
<td>Vanessa Thompson</td>
<td>Spartanburg Regional Healthcare System</td>
</tr>
<tr>
<td>Vernon Hayes</td>
<td>Hope Center for Children, Inc.</td>
</tr>
</tbody>
</table>
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>SECTION</th>
<th>DESCRIPTION</th>
<th>PAGE #</th>
<th>APPENDIX</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Executive Summary</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Recommendations and supportive detail</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MATRIX OF RECOMMENDATIONS BY SOURCE/PROCESS</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Methodology for Child/Adolescent Behavioral Health Study</td>
<td>22</td>
<td>A</td>
</tr>
<tr>
<td>4.</td>
<td>Demographics of Spartanburg County, SC</td>
<td>24</td>
<td>B</td>
</tr>
<tr>
<td>5.</td>
<td>Overview of Spartanburg County, SC School System</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Epidemiology of Mental Health among Children/Adolescents</td>
<td>28</td>
<td>C</td>
</tr>
<tr>
<td>7.</td>
<td>Literature Search on Child/Adolescent Behavioral and Mental Health</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Benchmark Community Input</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Key Informant Interview Input</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Focus Group/Listening Session Input</td>
<td>38</td>
<td>D</td>
</tr>
<tr>
<td>11.</td>
<td>Evidence-Based Work Group Input</td>
<td>39</td>
<td>E</td>
</tr>
<tr>
<td></td>
<td>APPENDICES</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>A.</td>
<td>Steering Committee Contact Sheet</td>
<td>41</td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td>Demographics Presentation and Spreadsheet</td>
<td>42: Separate documents</td>
<td></td>
</tr>
<tr>
<td>C.</td>
<td>Epidemiology of Child/ Adolescent Mental Health (SC data)</td>
<td>43</td>
<td></td>
</tr>
<tr>
<td>D.</td>
<td>Focus Group transcripts</td>
<td>46</td>
<td></td>
</tr>
<tr>
<td>E.</td>
<td>Evidence Based Work Group minutes by four Age Groups</td>
<td>69</td>
<td></td>
</tr>
<tr>
<td>F.</td>
<td>South Carolina Compendium of Evidence-Based Strategies by Age</td>
<td>82</td>
<td></td>
</tr>
</tbody>
</table>
1. EXECUTIVE SUMMARY

Spartanburg County conducted an in-depth needs and resource assessment specific to child and adolescent behavioral and mental health from April to September 2019. The resulting report recommended the steps necessary to implement an efficient, effective, linguistically and culturally sensitive, and cohesive model in Spartanburg County, South Carolina. This model aims to increase the community’s capacity to improve child and adolescent behavioral and mental health outcomes.

For purposes of this study, the age range of children and adolescents were grouped into four (4) quadrants: pre-school (0-4), child (5-12), adolescent (13-17) and young adult (18-21+).

Behavioral health issues were defined as issues presenting from sources such as pre-school, school, middle school and/or college that resulted in intervention at the school, community or healthcare system. A source of behavioral health issues from secondary research was the Behavioral Risk Factor Surveillance System (BRFSS).

Mental health issues were defined as diagnosed mental health conditions with issues receiving data from the South Carolina Office of Adolescent Health due to low rates by zip code or presenting diagnoses among these age groups. The four (4) issues requested were anxiety, depression, suicidal ideation and substance use. Mood or conduct disorders were considered an interim category between behavioral and mental health.

The goals of the Child/Adolescent Behavioral Health Study are to:

(1) Explore and share county-level data related to child and adolescent mental and behavioral health. with data disaggregated by race, ethnicity, and income, where possible.

(2) Examine community attitudes and awareness of mental and behavioral health among children and adolescents, including differences in attitudes and awareness among diverse communities within Spartanburg.

(3) Identify and thoroughly examine the existing systems that interact with children and adolescents. a. Highlight their strengths in preventing and/or intervening in mental and behavioral health issues. b. Pinpoint specific challenges and barriers that interfere with effective prevention and/or intervention efforts.

(4) Inventory local resources and existing accessibility of programs, services, and supports, making note of resources that are culturally sensitive/competent and available in languages of immigrant communities present in Spartanburg County.

(5) Research evidence-based and culturally competent strategies that could be deployed in school, medical, and community-based settings in Spartanburg County. This should include an understanding of what state and national initiatives are available to enhance the work in Spartanburg.

(6) Based on the landscape of child and adolescent mental health needs, community values and feasibility, develop key evidence-based recommendations for Spartanburg County that address policy, practice, and programming in school, community, and medical settings.
Process:

A Steering Committee of thirty local community mental health, school district representatives, and healthcare providers met over a five-month period to review information derived from primary and secondary research conducted by a consulting firm, Germaine Solutions.

Primary research included 22 key informant interviews, four (4) benchmark community interviews and five (5) focus groups involving over 75 individuals.

Secondary research included review of South Carolina data for Spartanburg County specific to child and adolescent demographics, mental and behavioral health issues and recommendations being considered by the Children's Trust in Columbia, South Carolina and statewide efforts underway by the South Carolina Department of Health and Environmental Control (DHEC).

For purposes of this study, the age range of children and adolescents were grouped into four (4) quadrants: pre-school (0-4), child (5-12), adolescent (13-17) and young adult (18-21+).

Behavioral health issues were defined as issues presenting from sources such as pre-school, school, middle school and/or college that resulted in intervention at the school, community or healthcare system. A source of behavioral health issues from secondary research was the Behavioral Risk Factor Surveillance System (BRFSS).

Mental health issues were defined as diagnosed mental health conditions with issues receiving data from the South Carolina Office of Adolescent Health due to low rates by zip code or presenting diagnoses among these age groups. The four (4) issues requested were anxiety, depression, suicidal ideation and substance use. Mood or conduct disorders were considered an interim category between behavioral and mental health.

Settings in the child/adolescent behavioral and mental health continuum included schools, community providers, and the healthcare system. Interventions encompassed the spectrum of prevention, intervention and postvention.
2. RECOMMENDATIONS

The following recommendations have been developed over the course of five (5) months through the input of a Steering Committee comprised of local mental and behavioral health professionals and advocates, as well as from a variety of other key informants and through youth and parent focus groups.¹ The leadership team, advancing this work through the Spartanburg County Behavioral Health Taskforce, is committed to a focus on both upstream and preventative efforts, while also examining the downstream impacts. We also recognize that these ten (10) recommendations are only the beginning of this work and that more opportunities for prevention and intervention across multiple systems will be realized as the work advances.


(1) Improve coordination and continuity across the systems of care to systematically address the intake, treatment, transition, and placement to improve the experience for providers and clients. To improve coordination, better awareness among all providers is needed about what medical and behavioral health care an adolescent can access without parental consent and at what age(s).

(2) Explore what it would take for Spartanburg County, SC to become a Trauma-Informed Community to more fully support and strengthen youth and families, with a strong focus on building resiliency among populations where data demonstrates a disparity in outcomes. While impossible to eliminate all Adverse Childhood Experiences, Spartanburg should focus on prevention and the root causes of trauma (i.e. violence, child abuse and neglect, substance abuse in the home) while also helping to build resilience at the individual, systemic, and societal levels.

(3) Use evidence-based strategies to form the basis of prevention, intervention, and postvention programs for all age groups and in all settings: schools, healthcare, and community. There are examples of strong evidence-based strategies in Spartanburg, but there are also gaps in evidence-based strategies across age groups, settings and areas of concern (i.e. anxiety, depression, substance use, and suicide) that still need to be addressed.

(4) Explore how payer sources, such as Medicaid, restrict access to care and needed services due to limits on the number of approved providers, identify and leverage additional resources (i.e. local and state partnerships, federal funding, grants), and advocate for reform, as appropriate. Spartanburg County should take the lead in advocating for opening of needed services through reimbursement.

(5) Spartanburg County School Districts should work with the Spartanburg Department of Mental Health to ensure that high-quality mental health counselors are embedded in ALL schools by 2022. To bolster the number of available mental health professionals and ensure success in 2020, develop short-term goals for training, recruitment, retention, and placement. Particular emphasis should be on recruiting and retaining mental health professionals who are experienced and can provide supervision to new professionals and those who are linguistically and culturally competent.

¹ Appendix A lists the members of the Steering Committee
(6) Medical settings (i.e. family practice, pediatric groups) should expand the model of embedding mental health counselors when volume is sufficient. Medical settings need to identify and prioritize how to meet the unique needs of children and youth presenting with mental health issues.

(7) Child psychiatry needs to be addressed as a critical resource to augment, not replace, telepsychiatry services. Ideally, physical access to at least one child psychiatrist would alleviate the lag in assessing children and adolescents. The SRHS Emergency Center should have at least one child psychiatrist available to see patients.

(8) The use of the SRHS Emergency Center for child/adolescent mental health issues not considered an emergency should be intentionally minimized through providing safe, supportive environments for children, youth and their caregivers as age appropriate. This would minimize exposure to trauma at the Emergency Center through use of evidence-based programs and high-quality mental health providers.

(9) Support parents/guardians/caretakers of children and teens by providing training and skill building in parenting, understanding trauma and resiliency, and support with handling their own behavioral and mental health challenges. Ensure existing evidence-based programs are available for communities most in need and are culturally and linguistically relevant.

(10) Support community efforts to reduce substance use among children and adolescents. Also, explore whether there are a sufficient number of providers specializing in alcohol and other drugs that are child/adolescent-friendly in Spartanburg.

Detail of each recommendation and justification is provided in the following pages.
DETAIL SUPPORTING RECOMMENDATIONS

(1) Improve coordination and continuity across the systems of care to systematically address the intake, treatment, transition, and placement to improve the experience for providers and clients. To improve coordination, better awareness among all providers is needed about what medical and behavioral health care an adolescent can access without parental consent and at what age(s).

Goals.

(3) Identify and thoroughly examine the existing systems that interact with children and adolescents.
   a. Highlight their strengths in preventing and/or intervening in mental and behavioral health issues.
   b. Pinpoint specific challenges and barriers that interfere with effective prevention and/or intervention efforts.

(4) Inventory local resources and existing accessibility of programs, services, and supports, making note of resources that are culturally sensitive/competent and available in languages of immigrant communities present in Spartanburg County.

Key Informant Interviews. Every key informant interview (22 out of 26 invitees) referenced placement, transition and coordination issues for children and adolescents in Spartanburg County. Recurrent reference was made to alternative use of Greenville County when Spartanburg County resources exist. The Resource Directory compiled as a result of the Spartanburg County Behavioral Task Force was commended, with augmented recommendation for at least quarterly meetings to research placement options.

Literature Review. The Literature Review cited placement and transition issues as a chronic gap for children and adolescents for behavioral health in addition to mental health issues. Over-use of the Emergency Department was cited.

Benchmark Communities. The four (4) benchmark communities and the State cited this issue as a high priority, with substantiation of over-referral to the Emergency Department.

Focus Groups. Focus Groups cited this issue with specific reference by the Spanish-Speaking (PASOS) group, in addition to the Provider group and Youth-Serving focus group.

State of South Carolina data. South Carolina data points to over-sensitization with liability by school systems, parents/caregivers and system-involved youth in referring to the emergency department versus availability of a drop-in or lower cost/acuity option and the need for an electronic, single portal to access availability of placement and/or transition resources.

Evidence-Based Strategies. The only Evidence-Based Strategy specifically referring to a Resource Directory is the ‘Specialized Program for Under-Served Youth’ which cites the need for an alternative to this high-acuity model. It also references the over-referral to Residential Settings and the Unconscious Bias to refer to high-acuity resources for minority children, specifically in the school setting.
(2) Explore what it would take for Spartanburg County, SC to become a Trauma-Informed Community to more fully support and strengthen youth and families, with a strong focus on building resiliency among populations where data demonstrates a disparity in outcomes. While impossible to eliminate all Adverse Childhood Experiences, Spartanburg should focus on prevention and the root causes of trauma (i.e. violence, child abuse and neglect, substance abuse in the home) while also helping to build resilience at the individual, systemic, and societal levels.

Goals.

(1) Explore and share county-level data related to child and adolescent mental and behavioral health. with data disaggregated by race, ethnicity, and income, where possible.

(2) Examine community attitudes and awareness of mental and behavioral health among children and adolescents, including differences in attitudes and awareness among diverse communities within Spartanburg.

(5) Research evidence-based and culturally competent strategies that could be deployed in school, medical, and community-based settings in Spartanburg County. This should include an understanding of what state and national initiatives are available to enhance the work in Spartanburg.

(6) Based on the landscape of child and adolescent mental health needs, community values and feasibility, develop key evidence-based recommendations for Spartanburg County that address policy, practice, and programming in school, community, and medical settings.

Key Informant Interviews. The importance of trauma-informed communities and a Compassionate Care model was made evident in all key informant interviews and during all process stages of this study. The awareness of the impact of Adverse Childhood Experiences (ACES) led to a systemic therapeutic goal of aspiring to reduce or eliminate ACES from Spartanburg County, South Carolina.

Literature Review. Trauma-informed communities, and the prevalence of Adverse Childhood Experiences, was referenced throughout the literature as the primary causative agent for childhood and adolescent behavioral and mental health issues.

Benchmark Communities. Both Mecklenburg County, North Carolina and Milwaukee, Wisconsin cited Trauma-Informed awareness as a specific Goal in their Recommendations (2/4 or 50%).

Focus Groups. Both the Foster Parents and Spanish-Speaking Homes (PASOS) focus groups in addition to the Provider Focus Group referenced ACES and Trauma-Informed Care as crucial issues in behavioral and mental health causation and resolution.

State of South Carolina data. The Children’s Trust, in their role conducting the South Carolina Behavior & Risk Factor Surveillance Survey, cited a 58.23% prevalence of at least one ACES in 2016-2017 versus 61.77% for South Carolina.

Evidence-Based Strategies.

(1) Adverse Childhood Experiences and Trauma-Informed Care.


California Evidence-Based Clearinghouse for Child Welfare - The CEBC provides child welfare professionals with easy access to vital information about selected child welfare related programs. The primary task of the CEBC is to inform the child welfare community about the research evidence -- studies that have been published in a peer-reviewed journal -- for programs being used or marketed in California. The CEBC also lists programs that may be less well-known in California but were recommended by the expert for that topic area. Thirty-six topic areas are covered. They include home visiting for child well-being, interventions for neglect, reunification, and trauma treatment for children and adolescents.

CrimeSolutions.gov - Most of the programs are for criminal justice, but some refer to social services and even health care. All topics listed are criminal justice, but if you look at the program description, it's clear that this would be useful for a wide community.

Evidence-Based Practices in the Context of Human Relationships - John Records is the executive director of the Committee on the Shelterless (COTS) in Petaluma, California. Many of the people who come to COTS from the streets have high “adverse childhood experiences” (ACE) scores. The program uses the Restorative Integral Support (RIS) model to address their trauma. Evans. (2011). Homelessness Resource Center.

Evidence-Based Treatments for Childhood Trauma - A Virginia Child Protection Newsletter devoted to evidence-based treatments. (Fall 2012).

FindYouthInfo.gov - Selecting Evidence-Based Programs - The Where Are You? section focuses on identifying what your organization is interested in addressing as a result of your needs, assets, priorities, capacity, and goals. The program directory on is one example of a registry that provides information about evidence-based programs; other federal program directories can be found here.

Home Visiting Evidence of Effectiveness Review: Executive Summary - HomVEE was launched in fall 2009 to conduct a thorough and transparent review of the home visiting research literature and provide an assessment of the evidence of effectiveness for home visiting program models that serve families with pregnant women and children from birth to age 5. U.S. Department of Health and Human Services. (October 2012).

National Child Traumatic Stress Network Empirically Supported Treatments and Promising Practices - The fact sheets linked from this page describe some of the clinical treatment and trauma-informed service approaches implemented by National Child Traumatic Stress Network centers, with the common goal of reducing the impact of exposure to traumatic events on children and adolescents.

NREPP - SAMHSA’s National Registry of Evidence Based Programs and Practices - The National Registry of Evidence-based Programs and Practices (NREPP) is a searchable online registry of mental health and substance abuse interventions that have been reviewed and rated by independent reviewers. The purpose of this registry is to assist the public in identifying scientifically based
approaches to preventing and treating mental and/or substance use disorders that can be readily disseminated to the field.

**OJJDP Model Programs Guide (MPG) database** - The Office of Juvenile Justice and Delinquency Prevention's Model Programs Guide (MPG) is designed to assist practitioners and communities in implementing evidence-based prevention and intervention programs that can make a difference in the lives of children and communities. The MPG database of over 200 evidence-based programs covers the entire continuum of youth services from prevention through sanctions to reentry. The MPG can be used to assist juvenile justice practitioners, administrators, and researchers to enhance accountability, ensure public safety, and reduce recidivism. The MPG is an easy-to-use tool that offers a database of scientifically proven programs that address a range of issues, including substance abuse, mental health, and education programs.

**Promising Futures -Interventions for Children & Youth database** - This section of the website is designed to provide up-to-date information on interventions and resources for children exposed to violence for domestic advocates and other service providers who work with families. The information provided has been collected through a national review of programs and interventions for children exposed to family violence and other forms of trauma. From Futures Without Violence. (2012).

**Safe Start Center's Research & Evaluation**

**Social Programs That Work** - The Coalition for Evidence-Based Policy created this website to identify those social interventions shown in rigorous studies to produce sizable, sustained benefits to participants and/or society.

**Trauma-Informed Care** - A nice collection of trauma-informed resources from Connecticut's Department of Children and Families. Includes links to Effective Interventions for Child Traumatic Stress. Note: not all hyperlinks work; please scroll down page to access desired information.

**Trauma-Informed Care and Trauma Services, SAMHSA** - Listed are some well-known trauma-specific interventions based upon psychosocial educational empowerment principles that have been used extensively in public system settings. Please note that these interventions are listed for informational and educational purposes only. NCTIC does not endorse any specific intervention.

**Trauma-Informed Care Models & Treatments** - A list from "TDMHSAS BEST PRACTICE GUIDELINES: Trauma-Informed Care." Tennessee Department of Mental Health and Substance Abuse Services. (Feb. 2013). p 58-68.

**Trauma-Informed Interventions: Clinical and Research Evidence and Culture-Specific Information Project** - A collaboration between the National Crime Victims Research and Treatment Center at the Medical University of South Carolina (MUSC) and the National Child Traumatic Stress Network (NCTSN). The purpose of this project was to identify trauma-focused interventions that have been developed and utilized with trauma-affected youth populations of various cultural backgrounds and to describe their level of cultural competence. This project also aims to describe the level of clinical and research evidence surrounding the use of specific trauma-informed treatment interventions with diverse cultural groups. (2008).
**UCLA PTSD Reaction Index for DSM-IV** - Video/Slides of administration and scoring of the UCLA PTSD Reaction Index for DSM-IV. From NCTSN. (2013).

**USICH - United States Interagency Council on Homelessness Research & Evaluation** - Significant research has been and is being conducted on homelessness across the federal government and throughout the country. There is tremendous opportunity to better understand and apply what is being learned by coordinating and sharing research across federal agencies and with states and local communities.

**Violence Prevention Evidence Base** - This tool provides access to abstracts from published studies that have measured the effectiveness of interventions to prevent violence. To be included in the database, studies must have measured the impact of interventions directly on violence. Studies have been selected through a systematic review of published academic literature and the full inclusion criteria for studies can be accessed via the menu bar. The abstracts can be searched by violence type, keywords and geographical area of implementation. World Health Organization (WHO). (2008)

**What Works for Health** -- From County Health Rankings & Roadmaps, published by the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation, a searchable database of evidence-based policies and programs than can improve health. This database that covers health behaviors, physical environment, clinical care and social and economic factors. Not all programs are trauma informed.

**Data Source:** [https://www.acesconnection.com/blog/evidence-based-programs-data](https://www.acesconnection.com/blog/evidence-based-programs-data)
(3) **Use evidence-based strategies to form the basis of prevention, intervention, and postvention programs for all age groups and in all settings: schools, healthcare, and community.** There are examples of strong evidence-based strategies in Spartanburg, but there are also gaps in evidence-based strategies across age groups, settings and areas of concern (i.e. anxiety, depression, substance use, and suicide) that still need to be addressed.

**Goals.**

(4) **Inventory local resources and existing accessibility of programs, services, and supports, making note of resources that are culturally sensitive/competent and available in languages of immigrant communities present in Spartanburg County.**

(5) **Research evidence-based and culturally competent strategies that could be deployed in school, medical, and community-based settings in Spartanburg County.** This should include an understanding of what state and national initiatives are available to enhance the work in Spartanburg.

(6) **Based on the landscape of child and adolescent mental health needs, community values and feasibility, develop key evidence-based recommendations for Spartanburg County that address policy, practice, and programming in school, community, and medical settings.**

**Key Informant Interviews.** All 22 key informant interview respondents were queried about current (18/22 responded) or desired (22/22 responded) awareness of, and use of, evidence-based strategies. The belief that the community, even mental health providers, were aware of current EB strategies, however, was refuted with a consistent request for a compendium of evidence-based strategies. The imperative, many felt, was to move up the spectrum to more preventive evidence-based practices versus interventional ones.

**Literature Review.** The literature review was strong on evidence-based practices, but not as detailed on impact. The prevention and postvention practices were not as detailed for children and adolescent nor for high-risk groups as desired.

**Benchmark Communities.** The benchmark communities referenced evidence-based practices but not with the priority that Spartanburg did.

**Focus Groups.** The Foster Parents and Provider focus groups discussed evidence-based strategies.

**State of South Carolina data.** An age-specific compendium of evidence-based strategies was developed by the State of South Carolina but blended a more scientific inventory with existing practices (see Appendix F).

**Evidence-Based Strategies.** Specific attention was paid to the three (3) stages of behavioral and mental health strategies in the June 13th Steering Committee at which four (4) work groups stratified by age (0-4: pre-school, 5-12: child, 13-17: adolescent and 18-21+: young adult) selected evidence-based strategies for prevention, intervention and postvention for the four (4) most common mental health issues – anxiety, depression, suicidal ideation and substance abuse. The results are displayed in Appendix E.
(4) Explore how payer sources, such as Medicaid, restrict access to care and needed services due to limits on the number of approved providers, identify and leverage additional resources (i.e. local and state partnerships, federal funding, grants), and advocate for reform, as appropriate. Spartanburg County should take the lead in advocating for opening of needed services through reimbursement.

Goals.

(1) Explore and share county-level data related to child and adolescent mental and behavioral health. with data disaggregated by race, ethnicity, and income, where possible.

(3) Identify and thoroughly examine the existing systems that interact with children and adolescents. a. Highlight their strengths in preventing and/or intervening in mental and behavioral health issues. b. Pinpoint specific challenges and barriers that interfere with effective prevention and/or intervention efforts.

(4) Inventory local resources and existing accessibility of programs, services, and supports, making note of resources that are culturally sensitive/competent and available in languages of immigrant communities present in Spartanburg County.

(6) Based on the landscape of child and adolescent mental health needs, community values and feasibility, develop key evidence-based recommendations for Spartanburg County that address policy, practice, and programming in school, community, and medical settings.

Key Informant Interviews. This issue, while not referenced by all 22 of the key informant interviews, was mentioned by 15 of those (70%), primarily providers. The issue surfaced in queries about differential access and wait times upon referral following screening or even upon diagnosis, to the start of therapy. Closed panels for reimbursement were specifically cited.

Literature Review. Inadequate mention of this barrier occurred in the literature.

Benchmark Communities. Only one out of four (25%) of the benchmark communities (Palmetto Coordinated System of Care – South Carolina) referenced this issue as a barrier. Since this is also South Carolina, it appears that the Recommendation to use Advocacy is a prudent choice.

Focus Groups. This issue was referenced in three out of the five focus groups (60%)—by the Providers, the Foster Parents group and by PASOS. The experience was striking in comparison to no or little wait times for commercially insured children/adolescents and choices for provider involvement.

State of South Carolina data. This is a goal cited by the current South Carolina Department of Health and Environmental Control (DHEC) Behavioral Health work group.

Evidence-Based Strategies. This is not referenced by any Evidence-Based Strategy.
(5) Spartanburg County School Districts should work with the Spartanburg Department of Mental Health to ensure that high-quality mental health counselors are embedded in ALL schools by 2022.

To bolster the number of available mental health professionals and ensure success in 2020, develop short-term goals for training, recruitment, retention, and placement. Particular emphasis should be on recruiting and retaining mental health professionals who are experienced and can provide supervision to new professionals and those who are linguistically and culturally competent.

Goals.

(3) Identify and thoroughly examine the existing systems that interact with children and adolescents.
   a. Highlight their strengths in preventing and/or intervening in mental and behavioral health issues.
   b. Pinpoint specific challenges/barriers that interfere with effective prevention and intervention efforts.

(4) Inventory local resources and existing accessibility of programs, services, and supports, making note of resources that are culturally sensitive/competent and available in languages of immigrant communities present in Spartanburg County.

(6) Based on the landscape of child and adolescent mental health needs, community values and feasibility, develop key evidence-based recommendations for Spartanburg County that address policy, practice, and programming in school, community, and medical settings.

Key Informant Interviews. The focus of much of the key informant interview responses was on the power of accessing the ‘place’ of the school setting. One troubling finding, however, was the rapidly growing incidence of behavioral issues among 3 to 4 year olds' with no mechanism, given the non-mandatory nature of kindergarten in South Carolina, to reduce or prevent let alone screen for these issues. The issue referenced in Recommendation #1, of placement and transition issues was keenly felt in referral from, and transition back into, the school setting. The practical ability to meet the goal of having mental health counselors in all public schools is over-shadowed by recruitment issues of new graduates coupled with enticement of existing counselors to practice in this setting.

Literature Review. The only article referencing embedding mental health counselors in schools is excerpted in the Literature Review. It recommends five (5) strategies:
   1) Create mental health programming based on data-driven decisions.
   2) Collaborate to address the mental health needs of students.
   3) Provide a tiered system of mental health support.
   4) Evaluate mental health services to ensure they are addressing the academic achievement gaps.
   5) Communicate the outcomes to key stakeholders. The author stressed the importance of principal buy-in, involving the guidance counselor and school nurse as a team and a collaborative approach with the family/guardian/caretaker to positively resolve issues.

Benchmark Communities. Mecklenburg County, North Carolina and Milwaukee, Wisconsin both focused on the key role of the school system.

Focus Groups. All focus groups stressed the importance of this setting in prevention, intervention and postvention with issues of bullying, negative discipline and suspension/expulsion and vaping.

Evidence-Based Strategies. Outlined in Appendix E. Evidence Based Work Groups with comments related to all four (4) age groups even the concern about lack of school as ‘place for 0-4 year olds.

---

2 COUNSELING TODAY, MEMBER INSIGHTS. “Five strategies to develop mental health models in schools”; by Dakota L. King-White March 12, 2018
(6) Medical settings (i.e. family practice, pediatric groups) should expand the model of embedding mental health counselors when volume is sufficient. Medical settings need to identify and prioritize how to meet the unique needs of children and youth presenting with mental health issues.

**Goals.**

(3) Identify and thoroughly examine the existing systems that interact with children and adolescents.
   a. Highlight their strengths in preventing and/or intervening in mental and behavioral health issues.
   b. Pinpoint specific challenges and barriers that interfere with effective prevention and/or intervention efforts.

(4) Inventory local resources and existing accessibility of programs, services, and supports, making note of resources that are culturally sensitive/competent and available in languages of immigrant communities present in Spartanburg County.

(6) Based on the landscape of child and adolescent mental health needs, community values and feasibility, develop key evidence-based recommendations for Spartanburg County that address policy, practice, and programming in school, community, and medical settings.

**Key Informant Interviews.** This was mentioned by community and healthcare system providers in 10 of the 22 key informant interviews (45%).

**Literature Review.** Inadequate attention was paid to the concept of embedding mental health counselors in private or child/adolescent primary care practices except related to screening.

**Benchmark Communities.** Only the Milwaukee, Wisconsin study referenced embedding mental health counselors in primary care, child-serving clinical practices to lessen discomfort with child/adolescent mental health and defray perceived liability issues.

**Focus Groups.** The provider focus group discussed this issue at length (Appendix D)

**State of South Carolina data.** No data.

**Evidence-Based Strategies.** This issue was discussed at length in the Evidence-Based Work Group related to Children (5-12 years of age), Appendix E.
(7) **Child psychiatry needs to be addressed as a critical resource to augment, not replace, telepsychiatry services.** Ideally, physical access to at least one child psychiatrist would alleviate the lag in assessing children and adolescents. The SRHS Emergency Center should have at least one child psychiatrist available to see patients.

**Goals.**

(1) Explore and share county-level data related to child and adolescent mental and behavioral health, with data disaggregated by race, ethnicity, and income, where possible.

(3) Identify and thoroughly examine the existing systems that interact with children and adolescents.
   a. Highlight their strengths in preventing and/or intervening in mental and behavioral health issues.
   b. Pinpoint specific challenges and barriers that interfere with effective prevention and/or intervention efforts.

(4) Inventory local resources and existing accessibility of programs, services, and supports, making note of resources that are culturally sensitive/competent and available in languages of immigrant communities present in Spartanburg County.

(6) Based on the landscape of child and adolescent mental health needs, community values and feasibility, develop key evidence-based recommendations for Spartanburg County that address policy, practice, and programming in school, community, and medical settings.

**Key Informant Interviews.** Extensive discussion occurred in all (100%) of the twenty-two key informant interviews about the issues surrounding lack of a child psychiatrist and the delayed access to diagnosis given the wait for telepsychiatry consults.

**Literature Review.** The importance of a child psychiatrist was referenced in Section 7. Literature Review despite the national shortage of these qualified personnel.

**Benchmark Communities.** This issue was referenced by the Mecklenburg County, North Carolina and Milwaukee, Wisconsin studies with a detailed Continuum of Care developed by Milwaukee.

**Focus Groups.** This issue was raised in all focus groups and prioritized as a top tier issue.

**State of South Carolina data.** South Carolina ranks 50th nationwide for access to mental health care services, according to Mental Health America.

**Evidence-Based Strategies.** *Not applicable*
(8) The use of the SRHS Emergency Center for child/adolescent mental health issues not considered an emergency should be intentionally minimized through providing safe, supportive environments for children, youth and their caregivers as age appropriate. This would minimize exposure to trauma at the Emergency Center through use of evidence-based programs and high-quality mental health providers.

**Goals.**

(1) Explore and share county-level data related to child and adolescent mental and behavioral health. with data disaggregated by race, ethnicity, and income, where possible.

(3) Identify and thoroughly examine the existing systems that interact with children and adolescents. a. Highlight their strengths in preventing and/or intervening in mental and behavioral health issues. b. Pinpoint specific challenges and barriers that interfere with effective prevention and/or intervention efforts.

(4) Inventory local resources and existing accessibility of programs, services, and supports, making note of resources that are culturally sensitive/competent and available in languages of immigrant communities present in Spartanburg County.

(6) Based on the landscape of child and adolescent mental health needs, community values and feasibility, develop key evidence-based recommendations for Spartanburg County that address policy, practice, and programming in school, community, and medical settings.

**Key Informant Interviews.** Extensive discussion occurred in all (100%) of the twenty-two key informant interviews about the issues surrounding inappropriate use of the Spartanburg Regional Healthcare System Emergency Center and the need for a restricted, private area for child and/or adolescent mental health. In addition, the recommendation was frequently made that a ‘drop-in’ or cooling off center be provided for behavioral health issues prior to referral to this high acuity setting.

**Literature Review.** The literature was replete with reference to designing alternatives to Emergency Center referral for child and/or adolescent mental or behavioral health referral with frequent mention of the referral occasioned by liability concerns. The inaccurate threat of suicidal ideation or self-harm was discussed as a trigger to avoid less punitive options.

**Benchmark Communities.** This recommendation was in every benchmark community study with reference to drop-in centers or in larger metropolitan areas, to Children’s Crisis Centers.

**Focus Groups.** All focus groups referenced this issue and deemed it among the top two issues to resolve in Spartanburg County.

**State of South Carolina data.** When the mental health systems are not adequate to address need, hospital emergency departments become sources of mental health treatment by default. In 2016, we know the charges related to mental health totaled nearly $12 million and 2017 was on track to meet that mark again.

**Evidence-Based Strategies.** Not applicable except as Promising Practices to develop drop-in centers or options to high acuity referral sites.
(9) Support parents/guardians/caretakers of children and teens by providing training and skill building in parenting, understanding trauma and resiliency, and support with handling their own behavioral and mental health challenges. Ensure existing evidence-based programs are available for communities most in need and are culturally and linguistically relevant.

Goals.

(1) Explore and share county-level data related to child and adolescent mental and behavioral health. with data disaggregated by race, ethnicity, and income, where possible.

(2) Examine community attitudes and awareness of mental and behavioral health among children and adolescents, including differences in attitudes and awareness among diverse communities within Spartanburg.

(3) Identify and thoroughly examine the existing systems that interact with children and adolescents. a. Highlight their strengths in preventing and/or intervening in mental and behavioral health issues. b. Pinpoint specific challenges and barriers that interfere with effective prevention and/or intervention efforts.

(4) Inventory local resources and existing accessibility of programs, services, and supports, making note of resources that are culturally sensitive/competent and available in languages of immigrant communities present in Spartanburg County.

(5) Research evidence-based and culturally competent strategies that could be deployed in school, medical, and community-based settings in Spartanburg County. This should include an understanding of what state and national initiatives are available to enhance the work in Spartanburg.

(6) Based on the landscape of child and adolescent mental health needs, community values and feasibility, develop key evidence-based recommendations for Spartanburg County that address policy, practice, and programming in school, community, and medical settings.

Key Informant Interviews. Over eighty percent (82%) or 18 of the 22 key informant interviews referenced this goal with frequent mention of programs such as the Compassionate Schools, Triple P and Strengthening Families.

Literature Review. The school setting and parental/guardian/ caretaker role was frequently cited, with issues about trauma-informed care, chaotic households and lack of parenting skills reviewed as causative factors.

Benchmark Communities. Mecklenburg County, North Carolina and Milwaukee, Wisconsin cited the crucial role of parenting but not at the detailed level of Spartanburg.

Focus Groups. Two of the five (40%) focus groups involved parents—foster parents and PASOS.

State of South Carolina data. Data was available from the three (3) referenced programs.

Evidence-Based Strategies. Compassionate Schools, Triple P and Strengthening Families.
Support community efforts to reduce substance use among children and adolescents. Also, explore whether there are a sufficient number of providers specializing in alcohol and other drugs that are child/adolescent-friendly in Spartanburg.

Goals.

Examine community attitudes and awareness of mental and behavioral health among children and adolescents, including differences in attitudes and awareness among diverse communities within Spartanburg.

Identify and thoroughly examine the existing systems that interact with children and adolescents. Highlight their strengths in preventing and/or intervening in mental and behavioral health issues. Pinpoint specific challenges and barriers that interfere with effective prevention and/or intervention efforts.

Inventory local resources and existing accessibility of programs, services, and supports, making note of resources that are culturally sensitive/competent and available in languages of immigrant communities present in Spartanburg County.

Based on the landscape of child and adolescent mental health needs, community values and feasibility, develop key evidence-based recommendations for Spartanburg County that address policy, practice, and programming in school, community, and medical settings.

Key Informant Interviews. Only 8 of the 22 (35%) of key informant interview respondents cited substance use, primarily vaping related to schools and disciplinary processes. Where substance use was referenced was in relation to parents/guardians.

Literature Review. The literature focused on substance use by parents/guardians and the impact upon children and adolescents.

Benchmark Communities. Substance use was not referenced in the benchmark community studies.

Focus Groups. Three focus groups (60%) discussed substance use related to parental/guardians with specific concern among the Foster Parent’s group of creating the need for removal of children from their biological parent(s) due to incarceration or legal or safety issues related to substance use. Foster Parents, PASOS and Youth-Serving were the three groups that explored this issue.

State of South Carolina data. Scant data is available and presented in the Literature Review (Section 7) for alcohol abuse and opioid use.

Evidence-Based Strategies. Not explored.
### MATRIX GUIDE: RECOMMENDATIONS BY PROCESS IN CHILD/ ADOLESCENT BEHAVIORAL & MENTAL HEALTH STUDY

<table>
<thead>
<tr>
<th>#</th>
<th>RECOMMENDATIONS</th>
<th>Key Informant Interviews (22)</th>
<th>Literature Review</th>
<th>Benchmark Studies/ Communities (5)</th>
<th>Focus Groups (5)</th>
<th>State of SC data</th>
<th>Evidence Based Strategies</th>
<th>Evidence Based Work group findings (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Improve coordination and continuity across the systems of care to systematically address the intake, treatment, transition, and placement to improve the experience for providers and clients.</td>
<td>✓</td>
<td>✓</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>2</td>
<td>Explore what it would take for Spartanburg County, SC to become a Trauma-Informed Community to more fully support and strengthen youth and families, with a strong focus on building resiliency among populations where data demonstrates a disparity in outcomes.</td>
<td></td>
<td>✓</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>3</td>
<td>Use evidence-based strategies to form the basis of prevention, intervention, and postvention programs for all age groups and in all settings: schools, healthcare, and community.</td>
<td>✓</td>
<td>✓</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>4</td>
<td>Explore how payer sources, such as Medicaid, restrict access to care and needed services due to limits on the number of approved providers, identify and leverage additional resources (i.e. local and state partnerships, federal funding, grants), and advocate for reform, as appropriate.</td>
<td>✓</td>
<td>✓</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>#</td>
<td>RECOMMENDATIONS</td>
<td>Key Informant Interviews (22)</td>
<td>Literature Review</td>
<td>Benchmark Studies/Communities (5)</td>
<td>Focus Groups (5)</td>
<td>State of SC data</td>
<td>Evidence Based Strategies</td>
<td>Evidence Based Work group findings (4)</td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------</td>
<td>-------------------</td>
<td>-----------------------------------</td>
<td>-----------------</td>
<td>-----------------</td>
<td>--------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>5</td>
<td>Spartanburg County School Districts should work with the Spartanburg Department of Mental Health to ensure that high-quality mental health counselors are embedded in ALL schools by 2022</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>6</td>
<td>Medical settings (i.e. family practice, pediatric groups) should expand the model of embedding mental health counselors when volume is sufficient.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>7</td>
<td>Child psychiatry needs to be addressed as a critical resource to augment, not replace, telepsychiatry services.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>8</td>
<td>The use of the SRHS Emergency Center for child/adolescent mental health issues not considered an emergency should be intentionally minimized through providing safe, supportive environments for children, youth and their caregivers as age appropriate.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>9</td>
<td>Support parents/guardians/caretakers of children and teens by providing training and skill building in parenting, understanding trauma and resiliency, and support with handling their own behavioral and mental health challenges.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>10</td>
<td>Support community efforts to reduce substance use among children and adolescents.</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
3. Methodology for Child/Adolescent Behavioral Health Study

The study commenced in April of 2019, with Steering Committee meetings planned monthly. Due to an intense focus group schedule occurring in July of 2019, this session was canceled. In addition, the planned September Steering Committee was determined to not be needed due to completion of the processes, approval of the Recommendations at the August meeting and consensus to move to implementation.

<table>
<thead>
<tr>
<th>MONTH</th>
<th>AGENDA</th>
<th>OUTCOME</th>
</tr>
</thead>
</table>
| April 11| Introduction to Steering Committee, Review of Goals and Process; Overview of Literature Search and Basic Demographics of Children and Adolescents in Spartanburg County | • Successful Project Launch  
• Contact List of Steering Committee  
• Interview Schedule review  
• Demographic Overview  
• Literature Search Findings |
| May 16  | Review Epidemiologic Overview with detail by Area, Race, Ethnicity and Household Income; Discuss initial draft of Resource Inventory; Summarize Key Informant Interview (KII) findings | • Epidemiologic Overview of Mental and Behavioral Health among Children and Adolescents in Spartanburg County compared to S.C. and U.S.  
• Resource Inventory  
• KII Summary Findings |
| June 13 | Review existing Continuum of Care for Child and Adolescent Health and discuss Barriers/Gaps to Future Desired State | • Graphic display (with extensive detail) of existing Continuum of Care  
• Display of future desired Continuum of Care showing gaps  
• Draft Action Plan to reduce Barriers and close Gaps  
• Estimate of Unmet Need |
| July 11 | Review results of Consumer Focus Groups and Findings from Provider Survey | • Findings from consumer focus groups (children, adolescents and family members) regarding access to child and adolescent mental and behavioral health services  
• Estimation of Unmet Service Need  
• Comparison of Consumer Findings to Provider Input |
| August 22| Review Draft Report, Presentation and Infographic with focus on Action Items and Return on Investment (Financial & Social) | • Draft Report  
• Draft Presentation summarizing findings and Action Plan  
• Draft Infographic |
| September 12| Community Forum | Presentation of Findings, High-Level Action Plan and Infographic summarizing Study and Next Steps |
# SPARTANBURG COUNTY, SC: CHILD/ADOLESCENT BEHAVIORAL HEALTH STEERING COMMITTEE

<table>
<thead>
<tr>
<th>#</th>
<th>CONTACT</th>
<th>ORGANIZATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Alan Eggert</td>
<td>Spartanburg School System: School District 6</td>
</tr>
<tr>
<td>2</td>
<td>Carey Rothschild</td>
<td>Spartanburg Regional Healthcare System</td>
</tr>
<tr>
<td>3</td>
<td>Cathy Sparks</td>
<td>EMERGE</td>
</tr>
<tr>
<td>4</td>
<td>Colin Bauer</td>
<td>Spartanburg School System: School District 7</td>
</tr>
<tr>
<td>5</td>
<td>Deb Foreman</td>
<td>PFLAG</td>
</tr>
<tr>
<td>6</td>
<td>Donald Mims</td>
<td>Spartanburg School System: School District 7</td>
</tr>
<tr>
<td>7</td>
<td>Heather Witt</td>
<td>United Way of the Piedmont</td>
</tr>
<tr>
<td>8</td>
<td>Jameson Smith</td>
<td>The Forrester Center</td>
</tr>
<tr>
<td>9</td>
<td>Jennifer Parker</td>
<td>University of South Carolina Upstate</td>
</tr>
<tr>
<td>10</td>
<td>Jessica Hamlett</td>
<td>ReGenesis Health Care</td>
</tr>
<tr>
<td>11</td>
<td>Josie Jones</td>
<td>South Carolina Department of Social Services</td>
</tr>
<tr>
<td>12</td>
<td>Lance Feldman</td>
<td>Eastern Carolinas Group; Child Psychiatrist</td>
</tr>
<tr>
<td>13</td>
<td>Laura Barbas Rhoden</td>
<td>Hispanic Alliance</td>
</tr>
<tr>
<td>14</td>
<td>Lauren Hulstrand</td>
<td>Wofford College</td>
</tr>
<tr>
<td>15</td>
<td>Molly Talbot-Metz</td>
<td>Mary Black Foundation</td>
</tr>
<tr>
<td>16</td>
<td>Natalia Valenzuela-Swanson</td>
<td>Mary Black Foundation</td>
</tr>
<tr>
<td>17</td>
<td>Patty Nodine</td>
<td>ReGenesis Health Care</td>
</tr>
<tr>
<td>18</td>
<td>PJ McEnroe</td>
<td>EMERGE</td>
</tr>
<tr>
<td>19</td>
<td>Polly Edwards-Padgett</td>
<td>Mary Black Foundation</td>
</tr>
<tr>
<td>20</td>
<td>Robyn Hussa Farrell</td>
<td>Mental Fitness</td>
</tr>
<tr>
<td>21</td>
<td>Roc Robinson</td>
<td>Spartanburg School System: School District 6</td>
</tr>
<tr>
<td>22</td>
<td>Roger Williams</td>
<td>South Carolina Department of Mental Health</td>
</tr>
<tr>
<td>23</td>
<td>Ruth Schoonover</td>
<td>Spartanburg School System: School District 3</td>
</tr>
<tr>
<td>24</td>
<td>Susan Richards</td>
<td>South Carolina Department of Juvenile Justice</td>
</tr>
<tr>
<td>25</td>
<td>Sabrina Richardson</td>
<td>Intrinsic Therapy, LLC</td>
</tr>
<tr>
<td>26</td>
<td>Sharyn Pittman</td>
<td>NAMI (National Alliance on Mental Illness): Spartanburg</td>
</tr>
<tr>
<td>27</td>
<td>Tom Barnet</td>
<td>Spartanburg Co. Behavioral Health Task Force</td>
</tr>
<tr>
<td>28</td>
<td>Trish Beason</td>
<td>Spartanburg School System: School District 1</td>
</tr>
<tr>
<td>29</td>
<td>Vanessa Thompson</td>
<td>Spartanburg Regional Healthcare System</td>
</tr>
<tr>
<td>30</td>
<td>Vernon Hayes</td>
<td>Hope Center for Children, Inc.</td>
</tr>
<tr>
<td>31</td>
<td>Tracy Kulik</td>
<td>Germane Solutions</td>
</tr>
<tr>
<td>32</td>
<td>Robert Killeen</td>
<td>Germane Solutions</td>
</tr>
</tbody>
</table>

**APPENDIX A** Lists Steering Committee Members and Contact Information
4. Demographics

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Ages</td>
<td>313,888</td>
<td>152,188</td>
<td>161,700</td>
</tr>
<tr>
<td>Under 5 years</td>
<td>19,007</td>
<td>9,653</td>
<td>9,354</td>
</tr>
<tr>
<td>5 to 9 years</td>
<td>20,079</td>
<td>10,116</td>
<td>9,963</td>
</tr>
<tr>
<td>10 to 14 years</td>
<td>20,770</td>
<td>10,578</td>
<td>10,192</td>
</tr>
<tr>
<td>15 to 19 years</td>
<td>21,102</td>
<td>10,656</td>
<td>10,446</td>
</tr>
<tr>
<td>20 to 24 years</td>
<td>20,103</td>
<td>10,032</td>
<td>10,071</td>
</tr>
<tr>
<td></td>
<td>101,061</td>
<td>51,035</td>
<td>50,025</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Ages</td>
<td>313,888</td>
<td>152,188</td>
<td>161,700</td>
</tr>
<tr>
<td>Under 5 years</td>
<td>6.1%</td>
<td>9,653</td>
<td>9,354</td>
</tr>
<tr>
<td>5 to 9 years</td>
<td>6.4%</td>
<td>10,116</td>
<td>9,963</td>
</tr>
<tr>
<td>10 to 14 years</td>
<td>6.6%</td>
<td>10,578</td>
<td>10,192</td>
</tr>
<tr>
<td>15 to 19 years</td>
<td>6.7%</td>
<td>10,656</td>
<td>10,446</td>
</tr>
<tr>
<td>20 to 24 years</td>
<td>6.4%</td>
<td>10,032</td>
<td>10,071</td>
</tr>
<tr>
<td></td>
<td>32.2%</td>
<td>33.5%</td>
<td>30.9%</td>
</tr>
</tbody>
</table>

**Data Source:** American Community Survey, 2018; [www.census.gov](http://www.census.gov)

A detailed demographics presentation and spreadsheet are presented in Appendix A as separate documents (ppt and xls).

Percentiles by Age Groups and Race are provided below for Spartanburg County compared to South Carolina.
### TOTAL POPULATION

<table>
<thead>
<tr>
<th>Race</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spartanburg County</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>70.2%</td>
<td>70.0%</td>
<td>69.8%</td>
<td>69.5%</td>
<td>69.2%</td>
</tr>
<tr>
<td>Black</td>
<td>21.0%</td>
<td>21.1%</td>
<td>21.1%</td>
<td>21.1%</td>
<td>21.2%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>6.2%</td>
<td>6.3%</td>
<td>6.4%</td>
<td>6.6%</td>
<td>6.8%</td>
</tr>
<tr>
<td>Other</td>
<td>2.5%</td>
<td>2.6%</td>
<td>2.6%</td>
<td>2.7%</td>
<td>2.8%</td>
</tr>
<tr>
<td>South Carolina</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>64.7%</td>
<td>64.7%</td>
<td>64.7%</td>
<td>64.6%</td>
<td>64.6%</td>
</tr>
<tr>
<td>Black</td>
<td>28.0%</td>
<td>27.9%</td>
<td>27.8%</td>
<td>27.6%</td>
<td>27.5%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>5.3%</td>
<td>5.3%</td>
<td>5.4%</td>
<td>5.6%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Other</td>
<td>2.0%</td>
<td>2.1%</td>
<td>2.1%</td>
<td>2.2%</td>
<td>2.3%</td>
</tr>
</tbody>
</table>

### CHILDREN UNDER 1 YEAR

<table>
<thead>
<tr>
<th>Race</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spartanburg County</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>62.5%</td>
<td>62.6%</td>
<td>62.1%</td>
<td>62.2%</td>
<td>59.9%</td>
</tr>
<tr>
<td>Black</td>
<td>23.3%</td>
<td>23.7%</td>
<td>23.7%</td>
<td>25.0%</td>
<td>27.2%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>11.8%</td>
<td>11.4%</td>
<td>11.7%</td>
<td>10.4%</td>
<td>10.4%</td>
</tr>
<tr>
<td>Other</td>
<td>2.4%</td>
<td>2.3%</td>
<td>2.6%</td>
<td>2.4%</td>
<td>2.5%</td>
</tr>
<tr>
<td>South Carolina</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>56.0%</td>
<td>56.3%</td>
<td>56.1%</td>
<td>55.5%</td>
<td>55.2%</td>
</tr>
<tr>
<td>Black</td>
<td>32.0%</td>
<td>31.8%</td>
<td>31.5%</td>
<td>32.2%</td>
<td>32.6%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>9.9%</td>
<td>9.9%</td>
<td>10.5%</td>
<td>10.3%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Other</td>
<td>2.1%</td>
<td>2.0%</td>
<td>1.9%</td>
<td>2.0%</td>
<td>2.2%</td>
</tr>
</tbody>
</table>

### CHILDREN UNDER 5 YEARS

<table>
<thead>
<tr>
<th>Race</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spartanburg County</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>61.5%</td>
<td>62.4%</td>
<td>62.8%</td>
<td>62.4%</td>
<td>61.6%</td>
</tr>
<tr>
<td>Black</td>
<td>24.1%</td>
<td>23.5%</td>
<td>23.5%</td>
<td>23.9%</td>
<td>24.7%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>11.8%</td>
<td>11.6%</td>
<td>11.3%</td>
<td>11.2%</td>
<td>11.3%</td>
</tr>
<tr>
<td>Other</td>
<td>2.6%</td>
<td>2.5%</td>
<td>2.4%</td>
<td>2.5%</td>
<td>2.4%</td>
</tr>
<tr>
<td>South Carolina</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>55.3%</td>
<td>55.8%</td>
<td>56.0%</td>
<td>56.1%</td>
<td>56.0%</td>
</tr>
<tr>
<td>Black</td>
<td>32.7%</td>
<td>32.1%</td>
<td>31.8%</td>
<td>31.6%</td>
<td>31.7%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>10.0%</td>
<td>10.0%</td>
<td>10.1%</td>
<td>10.1%</td>
<td>10.1%</td>
</tr>
<tr>
<td>Other</td>
<td>2.0%</td>
<td>2.1%</td>
<td>2.1%</td>
<td>2.2%</td>
<td>2.2%</td>
</tr>
</tbody>
</table>

### CHILDREN UNDER 10 YEARS

<table>
<thead>
<tr>
<th>Race</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spartanburg County</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>61.7%</td>
<td>61.6%</td>
<td>61.6%</td>
<td>61.5%</td>
<td>61.3%</td>
</tr>
<tr>
<td>Black</td>
<td>24.0%</td>
<td>23.9%</td>
<td>24.1%</td>
<td>24.2%</td>
<td>24.5%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>11.7%</td>
<td>11.9%</td>
<td>11.8%</td>
<td>11.7%</td>
<td>11.6%</td>
</tr>
<tr>
<td>Other</td>
<td>2.6%</td>
<td>2.6%</td>
<td>2.5%</td>
<td>2.6%</td>
<td>2.6%</td>
</tr>
<tr>
<td>South Carolina</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>55.5%</td>
<td>55.5%</td>
<td>55.5%</td>
<td>55.6%</td>
<td>55.7%</td>
</tr>
<tr>
<td>Black</td>
<td>32.8%</td>
<td>32.6%</td>
<td>32.4%</td>
<td>32.2%</td>
<td>31.9%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>9.6%</td>
<td>9.7%</td>
<td>9.9%</td>
<td>10.0%</td>
<td>10.1%</td>
</tr>
<tr>
<td>Other</td>
<td>2.1%</td>
<td>2.1%</td>
<td>2.2%</td>
<td>2.2%</td>
<td>2.3%</td>
</tr>
<tr>
<td>CHILDREN UNDER 15 YEARS</td>
<td>RACE</td>
<td>2013</td>
<td>2014</td>
<td>2015</td>
<td>2016</td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>Spartanburg County</td>
<td>White</td>
<td>63.0%</td>
<td>62.8%</td>
<td>62.7%</td>
<td>62.2%</td>
</tr>
<tr>
<td></td>
<td>Black</td>
<td>23.3%</td>
<td>23.4%</td>
<td>23.4%</td>
<td>23.6%</td>
</tr>
<tr>
<td></td>
<td>Hispanic</td>
<td>10.8%</td>
<td>11.1%</td>
<td>11.3%</td>
<td>11.4%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>2.8%</td>
<td>2.8%</td>
<td>2.7%</td>
<td>2.8%</td>
</tr>
<tr>
<td>South Carolina</td>
<td>White</td>
<td>56.4%</td>
<td>56.4%</td>
<td>56.3%</td>
<td>56.2%</td>
</tr>
<tr>
<td></td>
<td>Black</td>
<td>32.7%</td>
<td>32.5%</td>
<td>32.2%</td>
<td>32.0%</td>
</tr>
<tr>
<td></td>
<td>Hispanic</td>
<td>8.8%</td>
<td>9.0%</td>
<td>9.3%</td>
<td>9.5%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>2.1%</td>
<td>2.1%</td>
<td>2.2%</td>
<td>2.3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHILDREN UNDER 18 YEARS</th>
<th>RACE</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spartanburg County</td>
<td>White</td>
<td>63.5%</td>
<td>63.3%</td>
<td>63.3%</td>
<td>62.9%</td>
<td>62.4%</td>
</tr>
<tr>
<td></td>
<td>Black</td>
<td>23.3%</td>
<td>23.3%</td>
<td>23.2%</td>
<td>23.3%</td>
<td>23.7%</td>
</tr>
<tr>
<td></td>
<td>Hispanic</td>
<td>10.3%</td>
<td>10.6%</td>
<td>10.7%</td>
<td>10.9%</td>
<td>11.1%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>2.9%</td>
<td>2.9%</td>
<td>2.8%</td>
<td>2.9%</td>
<td>2.9%</td>
</tr>
<tr>
<td>South Carolina</td>
<td>White</td>
<td>56.9%</td>
<td>56.8%</td>
<td>56.7%</td>
<td>56.6%</td>
<td>56.5%</td>
</tr>
<tr>
<td></td>
<td>Black</td>
<td>32.7%</td>
<td>32.5%</td>
<td>32.2%</td>
<td>32.0%</td>
<td>31.9%</td>
</tr>
<tr>
<td></td>
<td>Hispanic</td>
<td>8.3%</td>
<td>8.6%</td>
<td>8.8%</td>
<td>9.1%</td>
<td>9.3%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>2.1%</td>
<td>2.1%</td>
<td>2.2%</td>
<td>2.3%</td>
<td>2.3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHILDREN UNDER 21 YEARS</th>
<th>RACE</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spartanburg County</td>
<td>White</td>
<td>63.3%</td>
<td>63.2%</td>
<td>63.2%</td>
<td>62.9%</td>
<td>62.5%</td>
</tr>
<tr>
<td></td>
<td>Black</td>
<td>24.0%</td>
<td>23.8%</td>
<td>23.6%</td>
<td>23.7%</td>
<td>239.0%</td>
</tr>
<tr>
<td></td>
<td>Hispanic</td>
<td>9.8%</td>
<td>10.1%</td>
<td>10.3%</td>
<td>10.5%</td>
<td>10.8%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>2.9%</td>
<td>2.9%</td>
<td>2.8%</td>
<td>2.9%</td>
<td>2.9%</td>
</tr>
<tr>
<td>South Carolina</td>
<td>White</td>
<td>57.0%</td>
<td>57.1%</td>
<td>57.1%</td>
<td>57.0%</td>
<td>56.9%</td>
</tr>
<tr>
<td></td>
<td>Black</td>
<td>32.9%</td>
<td>32.5%</td>
<td>32.2%</td>
<td>32.0%</td>
<td>31.8%</td>
</tr>
<tr>
<td></td>
<td>Hispanic</td>
<td>8.0%</td>
<td>8.2%</td>
<td>8.5%</td>
<td>8.7%</td>
<td>9.0%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>2.1%</td>
<td>2.1%</td>
<td>2.2%</td>
<td>2.3%</td>
<td>2.3%</td>
</tr>
</tbody>
</table>

Data Source: Center for Disease Control & Prevention, National Center for Health Statistics. Vintage 2017 postcensal estimates of resident population of United States.
5. **Overview of Spartanburg School System**: The South Carolina public school system (prekindergarten through grade 12) operates within districts governed by locally elected school boards and superintendents. In South Carolina, there are 103 school districts in the public-school system in 1,239 schools serving 735,998 students. Spartanburg County has 7 school districts in 73 schools serving 47,994 students. Details by school district are provided below in addition to the state-funded School for the Deaf & Blind and a significant private school sector.

<table>
<thead>
<tr>
<th>SCHOOL</th>
<th># Schools</th>
<th>Locations</th>
<th>Size (# Students)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Spartanburg County School Districts</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>District 1</td>
<td>10</td>
<td>Campobello, Inman, Landrum</td>
<td>5,027 (2015-16)</td>
</tr>
<tr>
<td>2</td>
<td>15</td>
<td>Boiling Springs, Chesnee, Inman, Mayo</td>
<td>10,300 (2016-17)</td>
</tr>
<tr>
<td>3</td>
<td>9</td>
<td>Cowpens, Pacolet, Spartanburg</td>
<td>2,916 (2016-17)</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>Woodruff</td>
<td>2,738 (2016-17)</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
<td>Duncan, Moore, Reidville, Wellford</td>
<td>7,866 (2016-17)</td>
</tr>
<tr>
<td>6</td>
<td>15</td>
<td>Moore, Pauline, Roebuck, Spartanburg</td>
<td>11,147 (2016-17)</td>
</tr>
<tr>
<td>7</td>
<td>14</td>
<td>Spartanburg</td>
<td>8,000 (2016-17)</td>
</tr>
<tr>
<td><strong>Spartanburg School for the Deaf &amp; Blind</strong></td>
<td>1</td>
<td>Spartanburg with campus &amp; outreach through SC</td>
<td>81 (43 in Elementary &amp; Middle, 38 in HS)</td>
</tr>
<tr>
<td><strong>Private Schools in Spartanburg County</strong></td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oakbrook Preparatory</td>
<td>1</td>
<td>Spartanburg: Lower (K3-4&lt;sup&gt;th&lt;/sup&gt; grade), Middle (5-8&lt;sup&gt;th&lt;/sup&gt; grade) &amp; Upper Schools (9&lt;sup&gt;th&lt;/sup&gt;-12&lt;sup&gt;th&lt;/sup&gt; grade)</td>
<td>445</td>
</tr>
<tr>
<td>Spartanburg Day School</td>
<td>1</td>
<td>Lower, Middle &amp; Upper School</td>
<td>448</td>
</tr>
<tr>
<td>Spartanburg Preparatory School</td>
<td>1</td>
<td>Free public charter school</td>
<td>405</td>
</tr>
<tr>
<td>High Point Academy</td>
<td>1</td>
<td>Free Public Charter School</td>
<td>1,148</td>
</tr>
<tr>
<td>St. Paul the Apostle Catholic School</td>
<td>1</td>
<td>Spartanburg Catholic school</td>
<td>116</td>
</tr>
<tr>
<td>Spartanburg Christian Academy</td>
<td>1</td>
<td>Spartanburg: Pre-school through high school with home school program</td>
<td>403</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>80</td>
<td></td>
<td>51,041</td>
</tr>
</tbody>
</table>

Spartanburg County, South Carolina has a total population of 313,388 residents with 23.2% or 72,706 under the age of 18 (Source: [www.census.gov](http://www.census.gov)). Of this, 51,041 or 70% are in schools K-12.

*Data Source: Spartanburg Public Schools from School Districts.*  
*Data Source for Private Schools: South Carolina Department of Education.*
6. Epidemiology

Parent-reported information from the 2011-12 National Survey of Children’s Health showed that 1 out of 7 U.S. children aged 2 to 8 years had a diagnosed mental, behavioral, or developmental disorder (MBDD). Many family, community, and health-care factors were related to the children having MBDDs. Children with the following characteristics were more likely to have a MBDD:
1. Boys
2. Children age 6 to 8 years

One-fifth (20%) of children 13-18 live with a mental health condition per National Institute of Mental Health (NIMH), 50% of all lifetime cases of mental illness begin by age 14 and 75% by age 21. Approximately 1 in 5 youth aged 13–18 (21.4%) experiences a severe mental disorder. For children aged 8–15, the estimate is 13%.3

The average delay between onset of symptoms and intervention is 8-10 years, 37% of students with a mental health condition age 14 and older drop out of school—the highest dropout rate of any disability group, and 70% of youth in state and local juvenile justice systems have a mental illness.

- 11% of youth have a mood disorder
- 10% have a behavior or conduct disorder
- 8% have an anxiety disorder
- 5% suffer from depression
- Suicide is the 3rd leading cause of death in youth ages 10 – 24
- 90% of those who died by suicide had an underlying mental illness.4

From the South Carolina Behavior & Risk Factor Surveillance Survey in 2017:
- Behavioral Risk Factor Surveillance System (BRFSS) data show that, compared to the state average, Spartanburg residents reported a slightly higher number of “mentally unhealthy” days than the state average – 3.8 per month vs. 3.6 per month.
- Although 37% of BRFSS respondents indicated that mental health conditions interfered to some extent in normal activities in the past month, only 12% were receiving some sort of treatment. In the 2015 Youth Risk Behavior Risk Survey, 34% of LBGTQI youth reported being bullied at school or online, more than 40% considered suicide, 29% attempting suicide, and an overwhelming 60% reporting having been so sad or hopeless they stopped usual activities. All statistically significant compared to their heterosexual peers. This survey will be administered in four Spartanburg County School Districts in 2019.

From the recently released Gallup-Healthways Well-Being study polled nearly 338,000 U.S. adults from January 2016-December 2017 and ranked 186 communities for health and wellbeing. Overall, Spartanburg ranked 168th. For social/emotional health, Spartanburg ranked 145th.

---

Facts about mental disorders in U.S. children

- ADHD, behavior problems, anxiety, and depression are the most commonly diagnosed mental disorders in children
  - 9.4% of children aged 2-17 years (approximately 6.1 million) have received an ADHD diagnosis.\textsuperscript{5}
  - 7.4% of children aged 3-17 years (approximately 4.5 million) have a diagnosed behavior problem\textsuperscript{6}.
  - 7.1% of children aged 3-17 years (approximately 4.4 million) have diagnosed anxiety.\textsuperscript{ibid}
  - 3.2% of children aged 3-17 years (approximately 1.9 million) have diagnosed depression.\textsuperscript{ibid}

- Some of these conditions commonly occur together. For example:
  - Having another disorder is most common in children with depression: about 3 in 4 children aged 3-17 years with depression also have anxiety (73.8%) and almost 1 in 2 have behavior problems (47.2%).\textsuperscript{ibid}
  - For children aged 3-17 years with anxiety, more than 1 in 3 also have behavior problems (37.9%) and about 1 in 3 also have depression (32.3%).\textsuperscript{ibid}
  - For children aged 3-17 years with behavior problems, more than 1 in 3 also have anxiety (36.6%) and about 1 in 5 also have depression (20.3%). \textsuperscript{ibid}

- Depression and anxiety have increased over time
  - “Ever having been diagnosed with either anxiety or depression” among children aged 6–17 years increased from 5.4% in 2003 to 8% in 2007 and to 8.4% in 2011–2012.\textsuperscript{7}
  - “Ever having been diagnosed with anxiety” increased from 5.5% in 2007 to 6.4% in 2011–2012.\textsuperscript{ibid}
  - “Ever having been diagnosed with depression” did not change between 2007 (4.7%) and 2011-2012 (4.9%).\textsuperscript{ibid}

- Treatment rates vary among different mental disorders
  - Nearly 8 in 10 children (78.1%) aged 3-17 years with depression received treatment.\textsuperscript{ibid 5}
  - 6 in 10 children (59.3%) aged 3-17 years with anxiety received treatment.\textsuperscript{ibid 5}
  - More than 5 in 10 children (53.5%) aged 3-17 years with behavior disorders received treatment.\textsuperscript{ibid 5}

\textsuperscript{5} Danielson ML, Bitsko RH, Ghandour RM, Holbrook JR, Blumberg SJ. Prevalence of parent-reported ADHD diagnosis and associated treatment among U.S. children and adolescents, 2016. *Journal of Clinical Child and Adolescent Psychology*. Published online before print January 24, 2018
\textsuperscript{7} Bitsko RH, Holbrook JR, Ghandour RM, Blumberg SJ, Visser SN, Perou R, Walkup J. Epidemiology and impact of healthcare provider diagnosed anxiety and depression among US children. *Journal of Developmental and Behavioral Pediatrics*. Published online before print April 24, 2018
• Mental, behavioral, and developmental disorders begin in early childhood
  o 1 in 6 U.S. children aged 2–8 years (17.4%) had a diagnosed mental, behavioral, or
developmental disorder.\textsuperscript{8}

• Rates of mental disorders change with age
  o Diagnoses of depression and anxiety are more common with increased age.\textsuperscript{ibid 5}
  o Behavior problems are more common among children aged 6–11 years than children
younger or older.\textsuperscript{ibid 5}

Many family, community, and healthcare factors are related to children’s mental health.
• Among children aged 2-8 years, boys were more likely than girls to have a mental, behavioral,
or developmental disorder.\textsuperscript{ibid 7}
• Among children living below 100% of the federal poverty level, more than 1 in 5 (22%) had a
mental, behavioral, or developmental disorder.\textsuperscript{ibid 7}
• Age and poverty level affected the likelihood of children receiving treatment for anxiety,
depression, or behavior problems.\textsuperscript{ibid 7}

From the Primary Care office of SC DHEC determined in 2009 that the entire county of Spartanburg is a
Mental Health Professional Shortage Area for low-income residents. That is, there are not enough
providers to serve low-income residents who need them.

• The SC state ratio of providers to patients is an average of 1/300; the Spartanburg ratio is 1/600.
• Between 2012 and 2016, there were 241 deaths by suicide in Spartanburg County.

7. Literature Search

YOUTH BEHAVIORAL HEALTH LITERATURE REVIEW

Behavioral health incorporates every youth age group, from pre-school to young adult. There are three main settings of behavioral health and its impact: 1) healthcare, 2) schools, and 3) community-based organizations. Under the umbrella of behavioral health, the main mental disorders include a) anxiety b) depression c) suicidal ideation/attempts d) substance use/abuse and a collection of other disorders categorized as e) mood or conduct disorders/oppositional behavior and intellectual/development delays including ADHD and Autism Spectrum Disorder. The articles in this literature review cover a range of youth behavioral health topics of various age groups, including ages i) 0-4 ii) 5-12 iii) 13-17 iv) 18-21+

General Overview

Over fifteen percent (16.5%) of the 46.6 million children in the United States aged 6-17 have a mental health condition, with 49.4% of these diagnosed youth not receiving treatment. Pediatric Emergency Department visits increased by 55.8% between 2012 and 2016. 

Health Access in South Carolina

In 2015 in South Carolina, there were 10.0 primary care physicians per 10,000 population. In 2017, this resulted in a rank of 36th in the nation. In 2015, there were 4,362 per 100,000 population avoidable Emergency Department visits overall with 3,174 avoidable ED visits for those aged 0-17 per 100,000 population. Of the leading causes of hospitalization in children, major depressive disorder ranked 4th, with 710 hospitalizations. Public surveys conducted in South Carolina show that 4.1% rate the health of their community as very good or excellent, 26% rated it as good, 50.5% as fair, and 19.3% as poor.

Schools

Crisis Response in Schools

In schools, having a system in place to deal with crises and the mental health of students will provide everlasting benefits. By taking steps before a possible crisis occurs, schools can mitigate the impact of these events. If not taken seriously and if schools fail to follow the steps to the emergency preparedness intervention process, students and staff alike ace mental health issues such as Post-traumatic stress disorder (PTSD), and secondary trauma. These lead to emotional, psychological, and social well-being impact including poor school performance, substance abuse, causing harm to others, and violence.

Health Care Systems

Of the seven million children and youth who experienced a serious emotional disturbance (SED) less than 5% received multi-systemic therapy or therapeutic foster care, and 7% received functional family therapy. There is lack of consistency in models, delay and lag of new models coming into place, and

---

10 Access to Health Care SC
11 Assessment Results SC
12 Assessment Results SC
lack of models that show why there is this gap in treatment. The combination of evidence-based medicine and customization needs to derive efficacious models of care.  

Mental Health Counselors in Schools

Five (5) recommendations were issued in this article imploring use of mental health counselors in schools. These are:
1) Create mental health programming based on data-driven decisions.
2) Collaborate to address the mental health needs of students.
3) Provide a tiered system of mental health support.
4) Evaluate mental health services to ensure they are addressing the academic achievement gaps.
5) Communicate the outcomes to key stakeholders.

School nurses play a central role in developing mental health models in schools. School nurses have mental and physical health records provided by school personnel, parents and outside health care providers. Because of the time these professionals spend with students addressing other health concerns, they are able to screen for mental health concerns. This relationship provides school nurses opportunities to develop rapport with students. It is during these interactions that school nurses can detect changes in a student’s physical or mental health. School nurses can also provide insight to their colleagues about the mental health concerns they have observed within the school setting.

Teachers and administrators are additional important contributors to the development of mental health models in schools and must be equipped to identify mental health concerns in the school setting. In an effort to ensure that all school stakeholders collaborate and are properly equipped, regular meetings are essential. The more collaboration that takes place among the mental health team, teachers, parents, students and administrators, the more likely it is that students will succeed.

Provide a tiered system of support
Kelly Vaillancourt and colleagues described the benefits of a tiered system of mental health support in their 2013 article for the National Association of School Psychologists and the National Association of School Nurses. A tiered system of support for delivering mental health services provides levels of care to support students to succeed academically. Schools must use evidence-based strategies to ensure that the most effective, empirically supported practices are being used to help students succeed.

Tier one is the universal level of support in which all students have access to mental health services in a school setting. Within tier one, trauma-informed classroom methods are introduced to teachers, administrators and staff. Tier one includes implementation of a social/emotional curriculum for all students that is preventive in nature and that supports academic achievement by addressing social and emotional barriers. It is imperative to use a strengths-based approach that looks at the positive attributes of the students and builds upon those attributes to provide services for the students. Families should be made aware of the services and information being taught at school.

---

13 The ‘Best Practice’ Challenge by Monica E. Oss
14 COUNSELING TODAY, MEMBER INSIGHTS. “Five strategies to develop mental health models in schools”; by Dakota L. King-White March 12, 2018
Tier two is where targeted interventions are identified for students who need additional mental health support to eliminate barriers affecting them academically. Selective interventions are provided to students who exhibit behaviors that hinder them. Mental health services provided at the tier-two level consist of small groups, classroom behavior management strategies for teachers and staff, individual counseling and additional professional development for stakeholders related to social and emotional barriers to academic achievement. Collaboration among the team is extremely important.

The third tier is the most personalized, with intensive strategies provided based on the student’s needs. Typically, this is done through a comprehensive process in which key stakeholders gather to collaborate and strategize about the needs of the student. The team should consist of the mental health team members, the student, the student’s parents or guardians, teachers, administrators and outside agencies that work with the student and family. As highlighted by Kenneth Messina and colleagues’ 2015 article in *The Family Journal*, family buy-in is crucial at this level because of the importance of collaboration between home and school to support the student’s academic achievement and to identify the student’s strengths. Mental health and related services at this level include, but are not limited to, individual counseling provided by a mental health therapist, crisis intervention, outside counseling services, small group counseling, behavior plans and professional development for stakeholders.

**Crisis Continuum as it Relates to Health Systems**

A crisis continuum model involves treatment for youth in crisis with emphasis on safety and de-escalation of immediate crisis with stabilization in 72 hours. Ideally, a network of provider organizations supports strengths-based services. Almost all (94%) of youth served through a crisis continuum remained in current living situations throughout a crisis episode. Financial issues exist due to the complicated nature of braided funding.

**Suicidal Ideation/Attempts**

Suicide is the second leading cause of death for 15-34-year old. The Emergency Department is organized for triage and not for holding mental health patients, particularly children and adolescents. The result is a long hold, referral to telehealth or being sent home. If a suicidal attempt visits precipitates referral to the Emergency Department, a child or adolescent must be initially assessed, then assessed again the week after the visit for substance abuse, the week after psychiatric hospital intake and a week after discharge, and during the first weeks after starting an antidepressant. First steps need to be implementing best care in non-mental health specific settings like primary care. Unfortunately, assessments don’t happen routinely. This is proven by the statistics that within one month of a suicide attempt, 63% of individuals had a health care visit of any type and 44% of individuals had a mental health visit.  

---

15 Why Children’s Crisis Response Services Should Be Paid with Case Rates, Margaret M. Conner-Levin
16 Data & Decision Support for Suicide Assessment, Margaret M. Conner-Levin
As it relates to transgender adolescents
Female to male adolescents, aged 11-19 years old, reported the highest rate of attempted suicide (50.8%), followed by adolescents who identified as not exclusively male or female (41.8%), male to female adolescents (29.9%), questioning adolescents (27.9%), female adolescents (17.6%), and male adolescents (9.8%). The populations with the most heightened risk were female to male transgender and nonbinary transgender.²⁷

As it relates to Latinos
Latin females grades 9-12 had the highest rates of suicidal ideation (25.6%) compared to 22.8% of white peers. Male Latinos had rates of 12% compared to white males at 11.5%. All females had the highest rate of attempts at 15.1% compared to white females 9.8%, all males experienced suicidal ideation of 7.6% compared to white males at 3.7%. Migration caused increased stress and anxiousness. Family and community stressors affect Latino children’s mental health and cause depressive anxious symptoms and can lead to PTSD. Lack of knowledge, recognizing and seeking help, and language and cultural barriers have the biggest effect on why Latinos have higher prevalence rates than other minorities.¹⁸

Risk factors associated with Anxiety/Depression in Healthcare Research
The rate of adolescents who started having symptoms of a major depressive disorder increased by 52% between 2005 and 2017. For young adults at the ages of 18 and 25, the rate increased by 63% in that time period.¹⁹ In South Carolina, 14.5% of young adults aged 18-25 reported instance of depression. Diagnosing teens with depression is difficult due to moodiness, but drugs, alcohol, sexual promiscuity, and risk-taking or aggressive behavior are ways to detect this diagnosis. In the United States in 2015, 11.9% of adolescents were diagnosed with a major depressive disorder compared to South Carolina’s 11.0%. The Healthy People 2020 goal was 7.5%. In South Carolina during 2015, 3.4% of adolescents in grades nine through twelve reported having a suicide attempt that required medical attention, compared to national figures of 2.8%. The goal of 1.7% was not met.²⁰

ADHD
Between 1997 and 2016, the prevalence of attention-deficit/hyperactivity disorder (ADHD) in children and adolescents increased from 6.1% to 10.2% in the U.S.²¹

Youth Drug and Opioid
Almost fifteen percent (14.9%) of teens or young adults received an opioid prescription from 2005-2015 during Emergency Department (ED) visits. Dental problems resulted in 59.7% of adolescents receiving an opioid prescription and 57.9% of young adults.²² Those age 20-24 had a drug overdose rate of 18.1 per 100,000 population. The opioid overdose death rate for those 20-24 was 13.6 per 100,000.²³

Alcohol Abuse
Those 18-25 years of age had the second highest prevalence of binge drinking at 23.8%. Overdoses in children under 15 were rare, but the rate rose sharply in young adults.²⁴

¹⁷ Transgender Adolescent Suicide Behavior, Russell B. Toomey, Amy K. Syvertsen, Maura Shramko
**Community-Based Organizations**

**Foster Home Systems**
The number of youths in foster care increased by 1.5%, with 36% of new entries due to parental drug use. 52% are at risk of a behavioral or emotional problem and 45% have received outpatient behavioral health services. ²⁵

**Trauma Informed Care in Foster Systems**
90% of children in foster care have experienced a traumatic event, with nearly half reporting exposure to four or more types of traumatic events. ²⁶ Trauma screenings and information sharing must be improved for those in foster care. Rates of neglect, physical abuse, and sexual abuse are high in foster care. 85% of the children and adolescents were exposed to trauma, with 52% exposed to sexual abuse. Child maltreatment was associated with a greater likelihood of mental health disorders across a lifetime, including a tenfold increase in risk for Posttraumatic Stress Disorder as well as higher risk for other anxiety disorders, mood disorders, and substance use disorders. ²⁷

**Crisis Continuum as it Relates to Community Based Organizations and Health Systems**
Mobile response and stabilization services (MRSS) are straying from the traditional design of crisis management of screening and referral out. The objective is to stabilize outcomes, prevent unneeded Emergency Department visits and out of home placements, and de-escalate situations while keeping costs down. The approach is public health centered involving people through educational resources to bridge gaps. ²⁸

---

20 Behavioral Health SC
22 Pediatrics study: Percentages of teens and young adults who received opioid prescriptions, 2005 to 2015
23 Behavioral Health SC
24 Behavioral Health SC
25 Increasing Integration—Foster Care & Health Services, Sarah C. Threnhauser
26 Trauma-Informed Care for Youth in Foster Care, Carolyn M. Fratto
27 Prior Trauma Exposure for Youth in Treatment Foster Care, Shannon Dorsey, Barbara J. Burns, Dannie G. Southerland, Julia Revillion Cox, H. Ryan Wagner, and Elizabeth M. Z. Farmer
28 Making the Case for a Comprehensive Children’s Crisis Continuum of Care, Elizabeth Manley, L.S.W., Melissa Schober, M.P.M, Dayana Simons, M.Ed., Michelle Zabel, M.S.S.
8. Benchmark Community Input

(1) Palmetto Coordinated System of Care – South Carolina  
(2) Charlotte-Mecklenburg County, NC: December 2017  
(3) Palm Beach County, FL: 2017  
(4) Milwaukee County, WI: 2016-2017

<table>
<thead>
<tr>
<th>PCSC (SC)</th>
<th>Mecklenburg, NC</th>
<th>Palm Beach, FL</th>
<th>Milwaukee, WI</th>
</tr>
</thead>
</table>
| Still underway  
(1) Create portal for navigation for placement issues statewide (single number)  
a. Residential for crisis  
b. Respite care  
(2) Determine health outcomes/HEDIS measures for child/adolescent behavioral health  
(3) Develop system measures including length of time from first contact to intake, access to respite services, provider capacity, network adequacy  
(4) Finalize Key Performance Indicators (KPIs):  
a. Settings Compliance  
b. Level of Care determination  
c. Qualified Providers  
d. Service Plan development  
e. Health & Welfare  
f. Financial Accountability  
PREVENTION  
(1) Raise awareness about importance of early brain development  
(2) Adopt Child First Model  
(3) Provide more trauma-informed training  
ACCESS  
(4) Expand school-based mental health to more schools  
(5) Create more adolescent treatment beds  
(6) Establish a live-time database for crisis placements  
(7) Develop a provider clearinghouse  
(8) Facilitate more community-wide training  
(9) Increase cultural competence  
(10) Include mental health care in community resource centers  
QUALITY  
(11) Create a data warehouse  
(12) Eliminate duplication of management and coordination  
(13) Adopt a standardized intake & assessment  
(14) Evolve to an outcome-based model  
(15) Transition to whole-family model  
(16) Explore alternative approaches to care delivery  
(1) Develop mechanism for collaboration & oversight of behavioral health system in PBC, FL  
(2) Increase integration of behavioral health system with other systems in PBC, FL  
(3) Create opportunities to develop effective Crisis Stabilization System  
(4) Develop plan to educate and advocate for identified legislative changes  
(5) Create opportunities for housing for individuals with behavioral health issues  
(6) Conduct workforce analysis of Behavioral Health system  
(7) Create evaluation of efficacy of this Plan’s activities  
(1) Augment inpatient and outpatient mental health resources  
(2) Escalate resources to prevent with, and intervene with bullying including awareness  
(3) Increase housing for individuals with mental health  
(4) Support community mental health redesign underway  
(5) Re-integrate people with mental health into community  
(6) Augment community: school mental health partnerships  
(7) Implement Trauma-Informed Care  
(8) Continue to add mental health providers in community, school
9. Key Informant Interview Input
There were 26 people invited to participate in key informant interviews including members of the Child/Adolescent Steering Committee, other stakeholders including elected officials, healthcare system representatives and community leaders. Eighty-five (85%) or 22 chose to participate from April through June of 2019, with a summary of key findings displayed.

Themes

- **Consensus that supply does not equal demand with issues attributed to payer mix (i.e. Medicaid, under-insured, uninsured)**
  1. Medicaid and uninsured experience extremely long wait times to see providers (weeks)
  2. Appropriate services are often not offered to Medicaid patients
    ✓ Inappropriate settings for treatment like the SRHS Emergency Department
  3. Mental and behavioral health professionals often switch from public to private sector due to low pay, disrupts continuity of care

- **Acuity**
  1. Anxiety and suicidal ideation more common at a younger age;
  2. Issues with transition in school
    ✓ Moving from a punitive perspective to a rehabilitative mode
    ✓ Working with both students and parents in a partnership manner

- **Continuum of Care**
  1. What is the state required to offer at the prevention, treatment/intervention and follow-up levels?
  2. Residential treatment and transition back to schools and home
  3. Big hole: “Chill out” center for disruptive children
    1. Wake Forest created a “chill out” center and an urgicenter for children/adolescents
    2. ED not the best place for disruptive youth
  4. Crisis Stabilization Unit- discussed in 75% of key informant interviews but input from Behavioral Health Task Force that economies of scale not currently present in Spartanburg County

- **Clinical**
  ✓ Increased incidence of behavioral and mental health issues at young age
  ✓ Depression, anxiety
  ✓ Chronic Stress in chaotic family situations resulting in behavioral & conduct disorders
  ✓ ADHD and Autism Spectrum Disorder
  ✓ Suicide and Suicidal Ideation

- **At risk groups:**
  1. Children in poverty and chaotic family environments
  2. Developmentally disabled
  3. LGBTQI+
  4. Children in Spanish-speaking households

- **Barriers:**
  ✓ Generational Poverty
  ✓ Health Insurance Coverage
  ✓ Long appointment wait time for Medicaid patients
  ✓ Poor Parenting Skills
  ✓ Transportation
10. Focus Group/Listening Session Input

Five (5) focus groups or individual listening sessions have occurred with 50 individuals participating in these sessions. Sessions occurred from mid-June to early August 2019.

<table>
<thead>
<tr>
<th>Adolescent Listening Session</th>
<th>Foster Parents Focus Group</th>
<th>Provider Focus Group</th>
<th>PASOS Focus Group</th>
<th>Youth-Serving Organizations Focus Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colin Bauer</td>
<td>Vernon Hayes/Josie Jones</td>
<td>Carey Rothschild</td>
<td>Natalia Valenzuela-Swanson</td>
<td>Janet Christy/ Mary Black Foundation</td>
</tr>
<tr>
<td>Week of June 17</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 adolescents</td>
<td>2 foster parents/3 providers</td>
<td>10 providers</td>
<td>18 Spanish-speaking only individuals</td>
<td>8 individuals</td>
</tr>
</tbody>
</table>

1) Hard to get children seen right away if public health (vs private)
   - No referral if not on DSS 'problem list' post forensic interview
   - Must rise to level of Juvenile Justice for mental health evaluation
2) School system
   - Hard to get group convened for an IEP (Individualized Education Plan) for Special Needs Children. Often access services in other counties. Guidance Counselor sets up IEP meeting.
3) Issues seen:
   - Oppositional disorders
   - Obsessive Compulsive Disorder
   - Depression
   - I/DD esp. Autism
   - Suicidal ideation
   - Not substance use in children but multiple cognitive issues due to drug use among biological parents – Easier to access private agencies (EMERGE, Healing Solutions)
   - Hard: Placement for uninsured outside William S. Hall
   - Transportation to and from services resulting in poor compliance despite desire to get help
   - Need to differentiate behavioral issues from mental health
   - Commitment to Trauma Informed Community/ACES/EB Strategies
   - Concern about ‘over-screening’ is lack of training by leveraged screeners
   - Alarming rise in 0-3-year old’s with disruptive behavior
   - Concern about lack of parenting skills
   - Commitment to standardized mental health counselors in schools
   - Commitment to MH counselors embedded in primary care offices
   - Fear of deportation
   - Bullying due to ethnicity, language difficulties
   - Reported high suicidal ideation
   - High rates of anxiety, depression reported by parents as they don’t perceive that they can legally send their children to higher education
   - Transportation as issue
   - Unsure of health care and social services system that reflects their language, culture and specific issues related to citizenship and fears
   - Adverse Childhood Experiences related to fear or reality of parent/guardian deportation, bullying.

- Children lack proper sleep: impact of social media, high sensory environ
- Mental health issues include self-isolation, anxiety, depression, anger, suicidal ideation
- Early sexuality combined with high social media exposure at early age a risk factor
- Parental absence and deficient “peopling” skills
- Spartanburg Mental Health only treats Medicaid and high Out-of-Pocket costs
- Issues for those who totally lack health insurance
- Substance Abuse
- Need for additional wellness resources, e.g.:
  - Mental health
  - Adolescent pediatric health
  - ADHD services
  - Transportation

Detailed transcripts of the Focus Groups/Listening Sessions are presented in Appendix C.
### 11. Evidence-Based Work Group Input

On June 13th, the third scheduled Steering Committee was refined to conduct work groups by age related to Evidence-Based Strategies. One of the groups, the 13-17-year Adolescent group, re-met at the scheduled fourth Steering Committee on July 11th (cancelled due to Focus Groups).

<table>
<thead>
<tr>
<th>0-4 years of age</th>
<th>5-12 years of age</th>
<th>13-17 years of age</th>
<th>18-21+ years of age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home/Community</td>
<td>Home/Community/School</td>
<td>Home/Community/School</td>
<td>Home/Community/School</td>
</tr>
<tr>
<td>Developmental delays with some anxiety or disruptive behavior from: a) mood disorders b) behavior disorders Most traced to prenatal use of drugs or alcohol, unstable home situations or intellectual/developmental delays.</td>
<td>Anxiety/Depression and Substance Use issues with less Suicidal ideation. Suicidal ideation starts to be an issue for 10-12-year-olds.</td>
<td>• Anxiety • Depression • Suicidal ideation • Suicide attempts • Substance use/ experimenting with drugs • Gender questioning • Emergence of Serious Mental Illness</td>
<td>• Anxiety • Depression • Suicidal ideation • Suicide attempts • Substance use/ experimenting with drugs • Gender questioning • Emergence of Serious Mental Illness</td>
</tr>
</tbody>
</table>

**Prevention**

<table>
<thead>
<tr>
<th>Prevention</th>
<th>Prevention</th>
<th>Prevention</th>
<th>Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthening Families</td>
<td>KiVa Anti-bullying</td>
<td>Bridge Program</td>
<td>Olweus</td>
</tr>
<tr>
<td>Good Behavior Game</td>
<td>Olweus Bullying Prevention</td>
<td>SC Suicidal Prevention</td>
<td></td>
</tr>
<tr>
<td>Stop Bullying!</td>
<td>Bullying No Way!</td>
<td>Suicide Prevention Task Force</td>
<td></td>
</tr>
<tr>
<td>Intensive Parent Model</td>
<td>SC Suicidal Prevention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strengthening Families</td>
<td>NAMI Ending the Silence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PATHS: Promoting Alternative Thinking Strategies</td>
<td>Flourish peer led resilience</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Intervention**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Intervention</th>
<th>Intervention</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Play therapy</td>
<td>Rehabilitation Behavioral Health Services (RBHS)</td>
<td>Rehabilitation Behavioral Health Services (RBHS)</td>
<td>Suicide Prevention Task Force</td>
</tr>
<tr>
<td>NAMI Family to Family</td>
<td>Triple P</td>
<td>Forrester Center levels of substance use</td>
<td>Parenting for very young parents</td>
</tr>
</tbody>
</table>

**Postvention**

<table>
<thead>
<tr>
<th>Postvention</th>
<th>Postvention</th>
<th>Postvention</th>
</tr>
</thead>
<tbody>
<tr>
<td>JUST ASK/SAFET TALK</td>
<td>CONNECT Postvention</td>
<td>CONNECT Postvention</td>
</tr>
</tbody>
</table>

Detailed transcripts of the Evidence-Based Work Group sessions are presented in Appendix D.
APPENDICES:

A. Steering Committee Contact Sheet
B. Demographic presentation and spreadsheet
C. Epidemiology of Child/Adolescent Mental Health
D. Focus Group transcripts
E. Evidence-based Work Group Minutes (4)
   1. Pre-School (ages 0-4)
   2. Child (ages 5-12)
   3. Adolescent (ages 13-17)
   4. Young Adult (ages 18-21+)
### APPENDIX A. STEERING COMMITTEE CONTACT SHEET

<table>
<thead>
<tr>
<th>CONTACT</th>
<th>ORGANIZATION</th>
<th>EMAIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alan Eggert</td>
<td>Spartanburg School System: District 6</td>
<td><a href="mailto:Aeggert@spart6.org">Aeggert@spart6.org</a></td>
</tr>
<tr>
<td>Amy Wilcox</td>
<td>South Carolina Department of Juvenile Justice</td>
<td><a href="mailto:amwilc@scdjj.net">amwilc@scdjj.net</a></td>
</tr>
<tr>
<td>Ann Marie Caldwell</td>
<td>Child Psychiatrist</td>
<td><a href="mailto:dracaldwell@bellsouth.net">dracaldwell@bellsouth.net</a></td>
</tr>
<tr>
<td>Carey Rothschild</td>
<td>Spartanburg Regional Healthcare System</td>
<td><a href="mailto:crothschild@srhs.com">crothschild@srhs.com</a></td>
</tr>
<tr>
<td>Cathy Sparks</td>
<td>EMERGE</td>
<td><a href="mailto:cathy.sparks@westgatefti.org">cathy.sparks@westgatefti.org</a></td>
</tr>
<tr>
<td>Colin Bauer</td>
<td>Spartanburg School System: District 7</td>
<td><a href="mailto:CWBauer@spart7.org">CWBauer@spart7.org</a></td>
</tr>
<tr>
<td>Deb Foreman</td>
<td>PFLAG</td>
<td><a href="mailto:debf@flagspartanburg.org">debf@flagspartanburg.org</a></td>
</tr>
<tr>
<td>Donald Mims</td>
<td>Spartanburg School System: District 7</td>
<td><a href="mailto:DOMims@spart7.org">DOMims@spart7.org</a></td>
</tr>
<tr>
<td>Heather Witt</td>
<td>United Way of the Piedmont</td>
<td><a href="mailto:heather.witt@uwpiedmont.org">heather.witt@uwpiedmont.org</a></td>
</tr>
<tr>
<td>Jameson Smith</td>
<td>The Forrester Center</td>
<td><a href="mailto:jsmith@theforrestercenter.org">jsmith@theforrestercenter.org</a></td>
</tr>
<tr>
<td>Jennifer Parker</td>
<td>University of South Carolina Upstate</td>
<td><a href="mailto:jpark@uscupstate.edu">jpark@uscupstate.edu</a></td>
</tr>
<tr>
<td>Jessica Hamlet</td>
<td>ReGenesis Healthcare</td>
<td><a href="mailto:jhamlett@myrhc.org">jhamlett@myrhc.org</a></td>
</tr>
<tr>
<td>Josie Jones</td>
<td>South Carolina Department of Social Services</td>
<td><a href="mailto:Josie.Jones@dss.sc.gov">Josie.Jones@dss.sc.gov</a></td>
</tr>
<tr>
<td>Kothleen Brady</td>
<td>Community Research Group</td>
<td><a href="mailto:kothleen@communityresearchgroup.com">kothleen@communityresearchgroup.com</a></td>
</tr>
<tr>
<td>Lance Feldman</td>
<td>Eastern Carolina; Child Psychiatrist</td>
<td>Dr <a href="mailto:lancefeldman@gmail.com">lancefeldman@gmail.com</a></td>
</tr>
<tr>
<td>Laura Barbas Rhoden</td>
<td>Hispanic Alliance</td>
<td><a href="mailto:BarbasRhodenLH@wofford.edu">BarbasRhodenLH@wofford.edu</a></td>
</tr>
<tr>
<td>Lauren Hulstrand</td>
<td>Wofford College</td>
<td><a href="mailto:HulstrandLK@wofford.edu">HulstrandLK@wofford.edu</a></td>
</tr>
<tr>
<td>Molly Talbot-Metz</td>
<td>Mary Black Foundation</td>
<td><a href="mailto:mmetz@maryblackfoundation.org">mmetz@maryblackfoundation.org</a></td>
</tr>
<tr>
<td>Natalia Valenzuela-Swanson</td>
<td>Mary Black Foundation</td>
<td><a href="mailto:nswanson@maryblackfoundation.org">nswanson@maryblackfoundation.org</a></td>
</tr>
<tr>
<td>Patty Nodine</td>
<td>ReGenesis Healthcare</td>
<td><a href="mailto:pnodine@myrhc.org">pnodine@myrhc.org</a></td>
</tr>
<tr>
<td>PJ McEnroe</td>
<td>EMERGE</td>
<td><a href="mailto:pj.mcenroe@emergetc.org">pj.mcenroe@emergetc.org</a></td>
</tr>
<tr>
<td>Polly Edwards-Padgett</td>
<td>Mary Black Foundation</td>
<td><a href="mailto:ppadgett@maryblackfoundation.org">ppadgett@maryblackfoundation.org</a></td>
</tr>
<tr>
<td>Robyn Husza Farrell</td>
<td>Mental Fitness</td>
<td><a href="mailto:rfarrell@mentalfitnessinc.org">rfarrell@mentalfitnessinc.org</a></td>
</tr>
<tr>
<td>Roc Robinson</td>
<td>Spartanburg School System: District 6</td>
<td><a href="mailto:RobinsR@spart6.org">RobinsR@spart6.org</a></td>
</tr>
<tr>
<td>Roger Williams</td>
<td>South Carolina Department of Mental Health</td>
<td><a href="mailto:roger.williams@scdmh.org">roger.williams@scdmh.org</a></td>
</tr>
<tr>
<td>Ruth Schoonover</td>
<td>Spartanburg School System: District 3</td>
<td><a href="mailto:rschoono@spartanburg3.org">rschoono@spartanburg3.org</a></td>
</tr>
<tr>
<td>Sabrina Richardson</td>
<td>Intrinsic Therapy, LLC</td>
<td><a href="mailto:sabrinaalmt@gmail.com">sabrinaalmt@gmail.com</a></td>
</tr>
<tr>
<td>Sharyn Pittman</td>
<td>NAMI (National Alliance on Mental Health): Spartanburg</td>
<td><a href="mailto:director@namispartenburgsc.org">director@namispartenburgsc.org</a></td>
</tr>
<tr>
<td>Susan Richards</td>
<td>SC Department of Juvenile Justice</td>
<td><a href="mailto:sprich@scdjj.net">sprich@scdjj.net</a></td>
</tr>
<tr>
<td>Tom Barnet</td>
<td>Spartanburg County Behavioral Health Task Force</td>
<td><a href="mailto:thomas224@charter.net">thomas224@charter.net</a></td>
</tr>
<tr>
<td>Trish Beason</td>
<td>Spartanburg School System: District 1</td>
<td><a href="mailto:trish.beason@spart1.org">trish.beason@spart1.org</a></td>
</tr>
<tr>
<td>Vanessa Thompson</td>
<td>Spartanburg Regional Healthcare System</td>
<td><a href="mailto:vthompson@srhs.com">vthompson@srhs.com</a></td>
</tr>
<tr>
<td>Vernon Hayes</td>
<td>Hope Center for Children, Inc.</td>
<td><a href="mailto:vernon@hopefc.org">vernon@hopefc.org</a></td>
</tr>
<tr>
<td>Tracy Kulik</td>
<td>Germane Solutions</td>
<td><a href="mailto:tkulik@germane-solutions.com">tkulik@germane-solutions.com</a></td>
</tr>
<tr>
<td>Robert Killeen</td>
<td>Germane Solutions</td>
<td><a href="mailto:rkilleen@germane-solutions.com">rkilleen@germane-solutions.com</a></td>
</tr>
</tbody>
</table>

*Italics denotes invitees that did not participate in the Steering Committee process.*
APPENDIX B. DEMOGRAPHIC PRESENTATION AND SPREADSHEET

*Please view separate presentation (Spartanburg Child and Adolescent Demographics.ppt) & Spreadsheet (Spartanburg Child and Adolescent Demographics.xls)*
APPENDIX C. EPIDEMIOLOGY OF CHILD/ADOLESCENT MENTAL HEALTH (South Carolina)

At-Risk Group:

Children in Foster Care by Age Group

<table>
<thead>
<tr>
<th>Location</th>
<th>Age Group</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spartanburg</td>
<td>0 to 5</td>
<td>115</td>
<td>149</td>
<td>173</td>
<td>173</td>
<td>150</td>
</tr>
<tr>
<td></td>
<td>6 to 12</td>
<td>124</td>
<td>141</td>
<td>172</td>
<td>153</td>
<td>173</td>
</tr>
<tr>
<td></td>
<td>13 to 17</td>
<td>57</td>
<td>73</td>
<td>118</td>
<td>101</td>
<td>112</td>
</tr>
<tr>
<td></td>
<td>18 and over</td>
<td>9</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>All ages (0 to 17)</td>
<td>305</td>
<td>368</td>
<td>469</td>
<td>434</td>
<td>443</td>
</tr>
<tr>
<td>South Carolina</td>
<td>0 to 5</td>
<td>1,229</td>
<td>1,347</td>
<td>1,461</td>
<td>1,485</td>
<td>1,639</td>
</tr>
<tr>
<td></td>
<td>6 to 12</td>
<td>1,089</td>
<td>1,207</td>
<td>1,242</td>
<td>1,280</td>
<td>1,456</td>
</tr>
<tr>
<td></td>
<td>13 to 17</td>
<td>1,045</td>
<td>1,135</td>
<td>1,171</td>
<td>1,196</td>
<td>1,252</td>
</tr>
<tr>
<td></td>
<td>18 and over</td>
<td>214</td>
<td>169</td>
<td>154</td>
<td>150</td>
<td>159</td>
</tr>
<tr>
<td></td>
<td>All ages (0 to 17)</td>
<td>3,577</td>
<td>3,858</td>
<td>4,028</td>
<td>4,028</td>
<td>4,111</td>
</tr>
</tbody>
</table>

**Data Source:** S.C. Department of Social Services, Office of Case Management (most recent report): Total Children in Foster Care on June 30, 2018 - County of Origin.
ADVERSE CHILDHOOD EXPERIENCES

<table>
<thead>
<tr>
<th>Location</th>
<th>Number of indicators present</th>
<th>2014 - 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spartanburg County</td>
<td>At Least One ACE</td>
<td>58.23%</td>
</tr>
<tr>
<td>South Carolina</td>
<td>At Least One ACE</td>
<td>61.77%</td>
</tr>
<tr>
<td></td>
<td>No ACES</td>
<td>37.08%</td>
</tr>
<tr>
<td></td>
<td>One ACE</td>
<td>25.72%</td>
</tr>
<tr>
<td></td>
<td>Two ACES</td>
<td>14.31%</td>
</tr>
<tr>
<td></td>
<td>Three ACES</td>
<td>14.14%</td>
</tr>
<tr>
<td></td>
<td>Four or More ACES</td>
<td>.06%</td>
</tr>
</tbody>
</table>


Definitions: ACE data are collected via the Behavioral Risk Factor Surveillance System (BRFSS) managed by the South Carolina Department of Health and Environmental Control (DHEC). The BRFSS is a cross-sectional, telephone-based survey of health-related risk behaviors, history of chronic health conditions, and preventative behaviors. Non-institutionalized adults 18 years or older are randomly selected to take part in the survey. The survey is conducted year-round using random digit dialing (RDD) techniques on both landlines and cell phones. Children's Trust collected the data through the BRFSS with funds provided through the community-based child abuse prevention funds (2014 and 2015) and the BlueCross BlueShield Foundation of South Carolina (2016-2018).
Children who have one or more emotional, behavioral or developmental conditions, 2016-17

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>NUMBER</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Carolina</td>
<td>228,685</td>
<td>24%</td>
</tr>
<tr>
<td>United States</td>
<td>13,192,727</td>
<td>21%</td>
</tr>
</tbody>
</table>

South Carolina ranks 38th in the United States (1 is best, 46th is worst with some states not reporting).

Data Source: Child Trends analysis of data from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, National Survey of Children’s Health.

The state-level data used here come from the National Survey of Children’s Health (NSCH). The NSCH includes information on approximately 50,000 children under age 18, with representative samples for each state. For more information on the NSCH, see http://childhealthdata.org/learn

Definitions: Children ages 2 to 17 with a parent who reports that a doctor has told them their child has autism, developmental delays, depression or anxiety, ADD/ADHD, or behavioral/conduct problems.
APPENDIX D. FOCUS GROUP TRANSCRIPTS

(1) Colin Bauer and Youth Listening Sessions: Week of June 17: 9 participants
(2) FOSTER PARENTS FOCUS GROUP: 2 participants

5:30 p.m. @ Mary Black Foundation July 16, 2019

Sponsors: Vernon Hayes, Hope Center for Children
            Josie Jones, South Carolina Department of Social Services

Attendee: Phil Clark (Just Say Something)

Facilitator: Tracy Kulik, Germane Solutions

Attendees: Maggie, foster mother from Chesnee with 2 foster children, 1 boy (7 years) and 1 girl (11)
           Zip code 29330
           Two (2) adopted boys that were fostered:
           ➢ 1 from birth that is 7 years old
           ➢ 1 from 14 months that is 14 years old and autistic
           Has fostered 17 children total
           Likes to help special needs children

           Megan, foster mother from Spartanburg, zip code 29302
           1 adopted child, 18 foster children total, all ages but prefers young children,
           4 of her own children 2-9-11-13
           Has fostered 18 children

Easy to deal with:
1) Taking care of children
2) DSS – easier now

Hard to deal with:
3) Getting children seen right away if public health:
   a. No referral if not on DSS ‘problem list’ post forensic interview
   b. Must rise to level of Juvenile Justice or other issue for mental health evaluation
4) School system
   a. Hard to get group convened for an IEP (Individualized Education Plan) for Special
      Needs Children
      i. Often access services in other counties esp. Greenville
      ii. Guidance Counselor sets up IEP meeting

Mental health issues frequently seen:
1) Oppositional disorders
2) Obsessive Compulsive Disorder
3) Depression
4) Intellectual/Developmentally Disabled especially if diagnosed on the Autism Scale
5) Suicidal ideation
6) Not substance use among children, but often inherit multiple cognitive issues due to drug use
   among biological parents – crack, meth and some opioids

Easier to access private agencies (EMERGE, Healing Solutions).
From Vern, the Children’s Advocacy Center (CAC) only takes children that are severely abused that have been witnessed. Trauma Informed Care is usually the Evidence Based Strategy employed. The Hope Center has created a new Clinical Support Service at the Meeting Street Academy site.

Younger Children often go to Pediatricians for mental health issues as there are just too many kids and not enough resources. Foster parents have issues getting children younger than 3 into services since pre-schools generally are full and don’t like to take foster children. Maggie commented that the Head Start program in Chesnee is a model for management of disruptive children.

Issues with day care cited at:
- Montessori schools/ EP Todd
- Early Learning Centers
- Meeting Street Academy
- Eastside Day Care
- 4K ‘full’

State Public option, ABC Voucher Day Cares ‘not the best’ (assist foster parents, biological parents and kinship with low-income access pre-school). From Josie, part of Economic Services Division/ SNAP program.

Sunshine Houses require extensive paperwork and a case worker.

Entry into pre-school programs like speech are difficult to access, can take up to 6 months on a waiting list, then child might be gone and has to start over.

Constant movement of foster children and their biological families, highly transient group.

EBP: Triple P, TIF Care/ACES, RBHS, Strengthening Families (Middle Tyger and Children’s Trust) --a 14-week program for children ages 6-11 that meets twice a week with graduation ceremonies and reunions. It offers meals, education, transportation and system navigation for children with mental health issues (Just Say Something).

SCHOOLS
District 7 uses Trauma Informed Care/ Adverse Childhood Experiences and RBHS (Rehabilitation Behavioral Health Services) through the Forrester Center and Spartanburg Area Community Mental Health (DMH) headed by Christian James. RBHS is a school based mental health program headed by an MSW hired by the School District.

Vern commented that the State of South Carolina has ‘closed’ participation for Medicaid reimbursement in RBHS due to their new ‘System of Coordinated Care’ with families needing to qualify for services.

Issue getting Medicaid cards with parents needing 30 days to get their card unless generated through DSS. DSS creates an ‘open line’ and works with Select Health to get the foster children Medicaid cards, typically within 24 hours.
Vern commented again that Select Health has closed their roster for the foster care network and has issues participating. The Hope Center is actively contracted with Molina, Absolute and WellCare.

GAP: COURT SYSTEM

Cases are often delayed; attorneys don’t show up especially if they are also legislators
Adoption hearing should be a positive event, although it often involves interstate biological parents who have to surrender parental rights.
TPR- Termination of Parental Rights
PPH – Permanency Planning Hearing

GAPS:
• Parent/Guardians could prevent issues if children were seen earlier. Few resources provided by the State.
• Lack of information/connection on ‘where to send’ children with mental health issues.
• If services known or available (i.e. respite care), transportation to them is an issue.

Often, foster parents’ default and use Greenville’s services

Don’t need more providers, just awareness of services and access to them.

Schools want services but need to be more collaborative with foster parents in addressing issues using a team approach with the School, DSS and foster parents and made aware when there is an issue. The approach should be to rally around the family to help the child as soon as possible.
PROVIDER FOCUS GROUP: 10 participants
11-12:20 p.m. @ AccessHealth July 23, 2019

Host: Carey Rothschild, SRHS
Facilitator: Tracy Kulik, Germane Solutions

<table>
<thead>
<tr>
<th>PARTICIPANT</th>
<th>ORGANIZATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Hope Garcia</td>
<td>Women &amp; Children’s, Spartanburg Regional Healthcare System</td>
</tr>
<tr>
<td>2 Jessica Hamlett</td>
<td>ReGenesis Healthcare</td>
</tr>
<tr>
<td>3 Liz Jodoin</td>
<td>University of South Carolina/Upstate: Director, Counseling Services</td>
</tr>
<tr>
<td>4 Tom Kowalski</td>
<td>Child Psychiatrist, VCOM (Edward Via College of Osteopathic Medicine)</td>
</tr>
<tr>
<td>5 PJ McEnroe</td>
<td>Director, EMERGE</td>
</tr>
<tr>
<td>6 Carey Rothschild</td>
<td>Director, Community Health</td>
</tr>
<tr>
<td>7 Cathy Sparks</td>
<td>EMERGE/University of South Carolina/Upstate</td>
</tr>
<tr>
<td>8 Vanessa Thompson</td>
<td>Director, Inpatient Psychiatry, Spartanburg Regional Healthcare System</td>
</tr>
<tr>
<td>9 Roger Williams</td>
<td>Director, South Carolina Department of Mental Health</td>
</tr>
<tr>
<td>10 Erin Wofford</td>
<td>Carolina Center for Behavioral Health</td>
</tr>
</tbody>
</table>

“What issues are easy to deal with regarding Child/Adolescent Behavioral or Mental Health in Spartanburg County, South Carolina and which ones are hard?”

Easy:
1) Youth are candid, ‘lost’, bullying source of referral or need for counseling, tremendous ACEs.
2) School-based counselors getting kids
   a. Four (4) contracts in 2018/Seven (7) in 2019 – Principal buy-in is the determining issue
   b. Manpower/Staffing issue
      i. Have authorization to hire
      ii. Pay disparity to private
      iii. USC Upstate with same issue
         1. Federal minimum is $55,000 for LPC and $65,000 for MSW
         2. South Carolina DMH starting salary is $36,000
            a. Reclassifying as SC Human Services Coordinator to break out as MH counselor to remedy part of gap

Hard:
1) Placement for uninsured outside William S. Hall, insured can find care
2) Parenting skills are lacking
3) Coordination of Care
4) Transportation to and from services resulting in poor compliance despite desire to get help

Issues:
1) Need to differentiate behavioral care from mental health care
2) School based counseling not standardized throughout seven (7) school districts
3) Age gaps for child/adolescents:
   a. 0-3/4 years of age: with kindergarten not mandatory in South Carolina, lack of ‘place’ for children to be observed, behavioral or mental health issues to be screened, referred, treated.
      i. Alarming number of children in chaotic households with poor or no parenting starting in school with high amounts of behavioral disruption or mental health issues.
4) Re-integration
SETTINGS

Colleges:

- Acute stay and then return to college require documentation that the young adult is ‘safe’.
- Avenue possible typically through academic appeal that they could not finish coursework due to treated issue.
- If no documentation of treatment or ongoing therapy, issues re-entering. Often the most challenging is from the Housing Director at Colleges.
- Doctors are not willing to provide documentation that young adult is ‘safe’ due to liability.
- Typical wording is that they are not ‘imminently dangerous to self or others, have no suicidal ideation and provide documentation of therapy, medications and treatment protocol.

Community:

- Pilot program of EMERGE now transferring to the Medical Group of Carolinas
- ‘Embed’ therapist in primary care practices and work with physician champion to provide treatment.
- Goal to provide concerted effort to remove barriers to mental health therapy. Resulted from experience that despite physician referral to therapy sessions, there were still a high amount of no shows.
- Rural areas (Union, Gaffney) worked very well, Pelham road did not, closing down due to saturation of private options.
- The Continuum of Care should be closed with this pilot as SRHS is hiring counselors and will use EPIC to remove any HIPAA barriers to reporting.
- Recurrence of theme in this pilot of distinguishing between Behavioral Issue and Mental Health Issue:
  > Appropriate to refer/ not to refer. Behavioral health issue could be resolved in more of an EAP (Employment Assistance Program) like 6-session vs. Mental Health issue requiring longer-term care and possibly, further triage.
  > Underlying assessment is to use Trauma-Informed care to determine if this issue is Oppositional Defiance or has a deeper ACES origin. If treating a condition with a deeper ACES origin applying behavioral health adjustment is just a band-aid that doesn’t resolve deeper condition.

Evidence-Based Strategies

Finding from other focus groups that ‘over-screening’ or lack of explanation of recurrent screening and inadequate language from staff enablers conducting screening has led to lack of acceptance of Evidence Based B Strategies.

Group all stated that they wouldn’t ever start explaining proposed care protocol as ‘evidence-based’ unless they faced strong pushback from parent/guardian. Issue is two-fold:

1) Screening not done because potentially not reimbursed or screening done by staff enabler that doesn’t accurately present rationale;

2) Parents uncomfortable when asked to leave room while screening is occurring (age 10-12 should be fine without parent/guardian and certainly more open).
There are special populations for which, despite the hundreds of Evidence-Based strategies that are approved, a research-validated EB doesn't yet exist. Categorized as 'Promising Practice'.

Some discussion occurred that the issue with parents/guardians and some youth is the desire for instant gratification/resolution of deep-seated issues. The screeners need to be properly trained in applying these instruments (PHQ-9).

- What screening should occur?
- How should the screening be conducted?
- Emphasize why screening is most effective with the child/adolescent without the parent/guardian/caretaker in the room (particularly for adolescents)
- Highly effective for major presenting issues:
  - Depression
  - Anxiety
  - ADD/ADHD (Attention Deficit Disorder/Attention Deficit-Hyperactivity Disorder)
  - Substance Use

College-level focus group providers stated that this group has high difficulty navigating the system. The providers have evolved to communicate almost entirely through social media:
- USC EMR secure text messages about appointment
- Facebook on Web listing mental health treatment options

FOCUS GROUP DISCUSSION GUIDE

This focus group is meant to obtain input from primary care providers and behavioral health clinicians serving children and teens in Spartanburg County. The intent is to determine what mental health and substance abuse resources are needed; any issues with knowing how, where, when to get services; and what can be done community-wide to support children and teens to grow up to be successful and healthy. Thank you for your input.

1) What is your awareness of the Continuum of Care for Child and Adolescent Mental Health services in Spartanburg County?

2) What is your awareness of the Continuum of Care for Child and Adolescent Substance Use services in Spartanburg County?

3) How well are these services integrated for Child/Teen Physical Health with Mental Health by Primary Care Clinicians?

4) How well are these services integrated for Child/Teen Physical Health and Substance Use Treatment by Primary Care Clinicians?

5) What are the areas of greatest need for Child/Teen Mental Health in Spartanburg County?

6) What are the areas of greatest need for Child/Teen Substance Use treatment in Spartanburg County?
7) IDENTIFIED NEEDS

a) Based on the above discussion, what are the biggest identified needs in service for child and teens in Spartanburg County for Mental Health services?
b) For Substance Use treatment?

8) IDENTIFIED GAPS & BARRIERS (Gap: Need and no service, Barrier: Need and trouble accessing)

a) Based on the above discussion what are the biggest identified gaps in services for child and teens in Spartanburg County for Mental Health services?
b) For Substance Use treatment?

9) For primary care clinicians: Do you use any Evidence-Based strategies (including screening) to determine mental health issues among children in your practice? Teens?

10) For primary care clinicians: Do you use any Evidence-Based strategies (including screening) to determine substance use issues among children in your practice? Teens?
General Health: This focus group took place in Spartanburg, SC at the Upstate Family Resource Center. The goal of this focus group was to hear from the Hispanic Spanish speaking community regarding their experiences when accessing general healthcare services and specifically in accessing mental health services for their children and adolescents.

Some of the activities associated with staying healthy in this community include:
- Walking
- Healthy eating (when accessible)
- Drinking plenty of water
- Kids playing sports
- Exercise
- Keeping medical appointments

Here is a list of positive and negative attributes identified by the community to stay healthy.

<table>
<thead>
<tr>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Park and Exercise</td>
<td>Lack of pediatric services in the evening/night</td>
</tr>
<tr>
<td>Parks with courts to play sports</td>
<td>High cost to access emergency departments</td>
</tr>
<tr>
<td>Hospitals are close and easy to access</td>
<td>Stores that sell alcohol to minors</td>
</tr>
<tr>
<td>Hospitals provide good quality care</td>
<td>High deductible even with health insurance</td>
</tr>
<tr>
<td>Hospitals provide translating services</td>
<td>Pharmacies selling alcohol and cigarettes</td>
</tr>
<tr>
<td></td>
<td>Fear of driving due to political climate</td>
</tr>
<tr>
<td></td>
<td>Lack of access to specialized medical services such as dialysis</td>
</tr>
<tr>
<td></td>
<td>No mental health services easily for children and adolescents</td>
</tr>
<tr>
<td></td>
<td>Little to no services to autistic individuals or individuals suffering from mental health disorders</td>
</tr>
</tbody>
</table>

Mental Health:

As it relates to mental health services, parents expressed a significant lack of available services compared to services offered for general health. The group agreed that access to general health services is easier to identify and access compared to mental health/substance use and abuse services.

Some children have access to a counselor at school but unfortunately the counselor is unable to provide mental health services to children and adolescents due to the lack in training and ability to handle a large case load. Parents expressed lack of readily available information for adults to properly identify services available in the community.
Some of the relevant issues causing anxiety/depression among their children and adolescents are the following:

- Bullying, a lot of children are being bullied in schools due to their race/ethnicity, body size, etc. There is a lack of access to sensitive education for children and parents who experience direct or indirect bullying activities.
- An increase in depression has been identified by parents who migrated with children who unfortunately cannot continue their high education due to their immigration status. A few parents provided an example of their kids who have gone through bad depression as they can’t seem to find a way to find resources to send their kids to college. In this case, children are not only impacted by this, parents also suffer from depression/anxiety and doubt their decision to move to this country as their children identify and relate to this country only.
- For parents, language is a barrier to access information as they at times can’t effectively communicate and gain access to information needed to assist their children in the best way to handle self-esteem issues, depression, etc.
- Due to the political nature of this country and the family separation that is currently taking place, undocumented parents of US citizen children have seen an increase in fear and anxiety due to separation of children from their parents.

Parents have not identified any substance abuse issues associated with their children; however, they are concerned that their children are constantly exposed to alcohol and tobacco products. One parent told a story of their child who told them that kids even drink alcohol onboard the school bus. Parents felt fortunate that as of right now none of their children demonstrate any substance use. However, they are concerned at the fact that they would not know where or how to get resources if needed.

In conclusion, there is a significant need for general healthcare services, especially pediatricians and a dire need for mental health services and information in the Spartanburg, SC area. Individuals present would like more services addressing the needs of the Hispanic community. Parents present took the time to share and exchange resources that have been utilized in the past.

TRANSCRIPT:

**SALUD GENERAL: GENERAL HEALTH**

(1) ¿Cuáles son los aspectos positivos de Spartanburg?
- Parques para hacer ejercicio
- Hospitales que están cerca/centros de emergencias cercanos
- Buena atención en los hospitales
- Hay traductores/intérpretes en los hospitales, no como en Ohio donde una señora había estado antes; también le atienden aún así sin seguro médico
- Boiling Springs tiene parques con canchas de fútbol
- PASOS brindan ayuda si no sabe dónde sacar información se puede pedirles ayuda.

(1) What are the positives of Spartanburg: General health?
- Exercise parks
(2) ¿Qué hacen las personas para estar sanas?
• Caminan mucho
• Comen de una forma saludable
• Hay muchos deportes para los jóvenes
• Van a los chequeos
• Cocina con comida fresca
• Toman agua
• Hacen deportes en las escuelas

Uno de los problemas sin embargo es que los supermercados no tienen la comida orgánica y que si la tienen es muy cara, a veces no es de la mejor calidad.

Hay que ir a las granjas para comprar los productos frescos y sólo se puede hacer durante una época del año. La buena calidad de los productos es difícil de tener. Para llegar a la granja tarda unos 45 minutos y no hay tanta variedad.

Mencionó que también cuando estaban en Florida había suplementos para comprar productos frescos que era mejor que WIC, por ejemplo, que solo da suplementos para productos específicos.

(2) What do people do to be healthy?
• They walk a lot
• Eat in a healthy way
• There are many sports for young people
• Go to checkups
• Cook with fresh food
• Drink water
• Do sports in schools

One of the problems, however, is that supermarkets do not have organic food and if they have it, it is very expensive, sometimes it is not of the best quality.

You have to go to the farms to buy fresh produce and it can only be done during a time of the year. The good quality of the products is difficult to have. To get to the farm takes about 45 minutes and there is not so much variety.

He mentioned that also when they were in Florida there were supplements to buy fresh products that was better than WIC, for example, which only gives supplements for specific products.

(3) ¿Cuáles son los problemas y preocupaciones en el condado de Spartanburg?
• No hay cuidado de salud por la noche y por los fines de semana. Hay que usar la sala de emergencias que es muy cara la visita.
• No hay suficientes centros de salud.
• Parece que hay que programar cuándo los niños se van a enfermar si no quieren pagar mucho.
• Hay necesidad de cuidado dental. Sólo hay la clínica de Regenesis.
• La falta de seguro es difícil para muchos, pero incluso para los que tienen seguro, puede que cueste unos $1000 por ponerle una corona. (Copagos son demasiado altos).
• La farmacia vende alcohol y cigarros. Para los niños, hay el mensaje que no está mal porque se venden en un lugar de “salud”

(3) **What are the problems and concerns in Spartanburg County?**
• There is no health care at night and on weekends. You have to use the emergency room that is very expensive to visit.
• There are not enough health centers.
• It seems that you have to schedule when children are going to get sick if they don't want to pay a lot.
• There is a need for dental care. There is only the ReGenesis clinic.
• The lack of insurance is difficult for many, but even for those with insurance, it may cost about $1000 to put a crown on. (Copayments are too high).
• The pharmacy sells alcohol and cigarettes. For children, there is the message that is not bad because they are sold in a place of “health”

(4) **¿Hay gente que usa drogas o alcohol para tratar sus problemas?**
• Se ha escuchado que hay menores de edad que usan alcohol y que hay algunas tiendas que les venden alcohol a los menores. También los padres a veces compran el alcohol.
• Tienen acceso a los cigarros eléctricos. Una madre nos comentó sobre su hijo de 16 años y que en el autobús casi todos tienen un cigarro eléctrico y quieren que él lo pruebe.
• Los niños salen más a menudo que en sus propios países y es un problema porque no saben bien los padres qué están haciendo.
• Los niños necesitan saber las expectativas tanto de los padres como de las escuelas. También necesitan empezar a hablar entre sí.
• Hay necesidad para programas educativos tanto para los padres como para los niños/adolescentes.
• Los niños y los adolescentes necesitan más actividad en general para que no haya tentación de usar drogas o alcohol (de uno de los adolescentes)

(4) **Are there people who use drugs or alcohol to treat their problems?**
• It has been heard that there are minors who use alcohol and that there are some stores that sell alcohol to minors. Also, parents sometimes buy alcohol.
• They have access to electric cigarettes. A mother told us about her 16-year-old son and that almost everyone has an electric cigarette on the bus and they want him to try it.
• Children leave more often than in their own countries and it is a problem because parents do not know well what they are doing.
• Children need to know the expectations of both parents and schools. They also need to start talking to each other.
• There is a need for educational programs for both parents and children / adolescents.

(5) **¿Qué le previene a la comunidad de estar sana?**
• Medicamentos (Son demasiado caros)
• Las vacunas también cuestan demasiado.
• Parece que el costo de la medicina es una barrera en general.
(5) What prevents the community from being healthy?
• Medications (They are too expensive)
• Vaccines also cost too much.
• It seems that the cost of medicine is a barrier in general.

(6) ¿Adónde va cuando está enfermo o necesita información?
• Access Health
• ReGenesis
• Pediatricas de Regional, pero hay un problema en cuanto a los pediatras y es que no se los mandan a los especialistas si son necesarios.
• No hay acceso a diális. Se les niegan diálisis por no tener seguro. Parece que solamente ocurre en este estado y no en otros. Carolina del Norte es mejor estado para la mayoría de los servicios de salud.
• Hay problemas con acceder los servicios de salud mental. Servicios de autismo, por ejemplo, son muy difíciles y que hay una lista de espera. Después de los 13 años de edad, hay pocos servicios. La lista de Charles Lee tienen más de 3000 personas y el seguro no les ayuda. Tienen que pagar por su propia cuenta para la mayoría de las cosas. Carolina del Norte sí tienen programas.
• En Spartanburg no hay especialistas. Hay que ir a Greenville para especialistas.

(6) Where do you go when you are sick or need information?
• Access Health
• ReGenesis
• Regional pediatricians, but there is a problem regarding pediatricians and they are not sent to specialists if necessary.
• There is no access to dialysis. They are denied dialysis for not having insurance. It seems to only occur in this state and not in others. North Carolina is a better state for most health services.
• There are problems with accessing mental health services. Autism services, for example, are very difficult and there is a waiting list. After 13 years of age, there are few services. Charles Lee’s list has more than 3000 people and insurance doesn’t help them. They have to pay on their own for most things. North Carolina does have programs.
• In Spartanburg there are no specialists. You have to go to Greenville for specialists.

(7) Salud Mental
• Problemas con tener acceso al cuidado y los servicios para los niños con autismo.
• Depresión: una de las madres nos habló de su hija que estaba tan deprimida que no quería seguir asistiendo a la escuela y estudiando. Quería volver a México y no recibió apoyo de la escuela.
• Problemas con bullying y que los niños no les dicen nada a sus padres sobre lo que está ocurriendo en sus vidas.
• No hay apoyo para los niños ni para los padres sobre autoestima y qué hacer cuando hay bullying sobretodo a los niveles superiores. Parece que, al nivel primario, las escuelas están más involucradas en el día a día. Los niños necesitan apoyo primariamente en inglés pero los padres necesitan información en español.
• Bullying en el autobús porque los chicos son hispanos. Parece que ha empezado a ser peor desde la llegada de Trump.
• Uno de los adolescentes nos dijo que los niños en Boiling Springs eran malos que siempre hacían chistes y se burlaban de los niños hispanos.
• Hay una necesidad para tener más educación y programas educativos sobre cómo ayudarles a sus hijos para los padres.
• Las dificultades en Middle School en cuanto a la transición, pero en cuanto al bullying también.
• Los programas para los padres deben ser en español y necesitan orientarles a los padres a las expectativas de la escuela. Según varios padres, hay más libertad en la escuela y por esa razón es difícil mantenerles a los chicos bajo control.
• En la mayoría de las escuelas, no hay intérpretes y tienen que usar a sus propios hijos como intérpretes.
• Hay programas tales como Triple P en Arcadia y PASOS que brindan estos servicios, pero la mayoría de los padres no sabían del programa.
• Necesitan más servicios para tratar bullying y la depresión que acompaña ese tratamiento. También mencionaron que los maestros no vigilan tanto a los niveles superiores (high school principalmente)

(7) Mental health
• Problems with having access to care and services for children with autism.
• Depression: one of the mothers told us about her daughter who was so depressed that she did not want to continue attending school and studying. He wanted to return to Mexico and did not receive support from the school.
• Problems with bullying and that children do not tell their parents anything about what is happening in their lives.
• There is no support for children or parents about self-esteem and what to do when there is bullying especially at higher levels. It seems that, at the primary level, schools are more involved on a daily basis. Children need support in English, but parents need information in Spanish.
• Bullying on the bus because the boys are Hispanic. It seems to have begun to be worse since Trump's arrival.
• One of the teenagers told us that the children in Boiling Springs were bad that they always made jokes and made fun of Hispanic children.
• There is a need to have more education and educational programs on how to help their children for parents.
• Difficulties in Middle School in terms of transition, but also in terms of bullying.
• Programs for parents must be in Spanish and need to guide parents to school expectations. According to several parents, there is more freedom in school and for that reason it is difficult to keep children under control.
• In most schools, there are no interpreters and they have to use their own children as interpreters.
• There are programs such as Triple P in Arcadia and PASOS that provide these services, but most parents did not know about the program.
• They need more services to treat bullying and the depression that accompanies that treatment. They also mentioned that teachers do not watch so much at higher levels (mainly high school)

(8) Situación nacional y cómo les afecta a los hispanos
• Varias personas hablaron de lo que está ocurriendo al nivel nacional y la separación de las familias. Muchos de ellos tienen miedo de que les van a pasar a ellos y que un día el padre o la madre no vaya a volver.
• Los niños tienen mucho miedo y están sufriendo mucho. Necesitan apoyo psicológico.
• Le ha afectado a una señora por lo menos que su marido fue tomado y su familia no sabe dónde está.
• “Es un cambio de vida total”
• Los niños preguntan “¿Por qué nos quieren llevar?” (En cuanto a la deportación)
• Hay mucho trauma por lo del gobierno
• Hay más bullying por eso
• Los niños sufren mucho
• El padre/la madre que sigue en casa tiene que tener conversaciones difíciles cuando llevan al otro padre
• Se necesita terapia y ayuda para estas situaciones
• También se necesitan más atracciones o eventos para los niños y adolescentes
• Necesitan saber de donde sacar información
• En Boiling Springs, hay necesidad de más intérpretes en los consultorios de los pediatras
• Necesitan más programas educativos sobre la salud
• Se nota que, para las personas con seguro médico, aún es difícil tener acceso a todos los servicios médicos
• Muchos de ellos usan la sala de emergencias por falta de tiempo y notan que no suelen diagnosticar bien.
• Hay mucho sufrimiento y la comunidad necesita estar unida y apoyada
• Una de las señoras habló de que en California le habían diagnosticado mal y cuando llegó a Carolina del Sur, cambiaron el medicamento y ahora se siente mejor. No mencionó adonde fue para su cuidado de salud.

(8) National situation and how it affects Hispanics
• Several people talked about what is happening at the national level and the separation of families. Many of them are afraid that they will happen to them and that one day the father or mother will not return.
• Children are very afraid and suffering a lot. They need psychological support.
• It has affected a lady at least that her husband was taken, and her family does not know where she is.
• “It's a total life change”
• Children ask, “Why do they want to take us?” (Regarding deportation)
• There is a lot of trauma about the government
• There is more bullying for that
• Children suffer a lot
• The parent who is still at home has to have difficult conversations when they take the other parent
• Therapy and help are needed for these situations
• More attractions or events are also needed for children and adolescents
• They need to know where to get information
• In Boiling Springs, there is a need for more interpreters in pediatricians' offices
• Need more health education programs
• It is noted that, for people with medical insurance, it is still difficult to have access to all medical services
• Many of them use the emergency room for lack of time and notice that they do not usually diagnose well.
• There is a lot of suffering and the community needs to be united and supported
• One of the ladies talked about being misdiagnosed in California and when she arrived in South Carolina, they changed the medication and now she feels better. He didn't mention where he went for his health care.
(g) Laura Barbas-Rhoden

1. ¿Qué hay de bueno?
   - Parques
   - Hospitales cercanos
   - Centros de emergencia
   - Buena atención
   - Gente para traducir
   - Aún si la persona no tiene seguro
   - Parques

What's good?
- Parks
- Nearby hospitals
- Emergency centers
- Good care
- People to translate
- Care even if the person doesn't have insurance

2. Para estar sanos
   - Comer más saludable
   - Caminar
   - Hacer ejercicio
   - Hacer deportes
   - Chequeos
   - Tomar agua
   - Comida orgánica y natural-cara/fuera de Spartanburg hay productos frescos en las granjas.
   - Es más difícil en invierno-45 minutos fuera de la ciudad, no hay tanta variedad.
   - Los recursos para madres son más en otros estados para productos naturales (Florida)

What do you do to be healthy?
- Eating healthier
- Walking
- Exercise
- Do sports
- Checkups
- Drinking water
- Organic and natural-face food/outside Spartanburg there are fresh produce on the farms.
- It's harder in winter-45 minutes out of town, there's not as much variety.
- Resources for mothers are more in other states for natural products (Florida)

3. Problemas
   - Pediatras de noche
   - El costo de atención de emergencias
   - He oído que...venden cerveza a menores de edad
   - Mi hijo dice que hacen vaping en el bus

German facilitator-asks specific question about drug use
• Necesitan más eventos para los jóvenes
• No están siempre en casa
• La biblioteca tiene algunas cosas para los adolescentes, pero necesitan más actividades para jóvenes
• Tienen cosas para niños de primaria, de 8-10 años
• Salud dental es difícil
• ReGenesis me ayudó
• (sigue pero no puedo distinguir lo que dice la señora al otro lado de la mesa)
• Veo que hasta en las farmacias venden cerveza y cigarrillos
• Deben tener más cosas para jóvenes buenos que los adolescentes vean esto no es bueno

3. Problems
• Pediatricians at night
• The cost of emergency care
• The library has some things for teens, but they need more activities for young people
• Have things for elementary school children, ages 8-10
• Dental health is difficult
• ReGenesis helped me

GERMANE FACILITATOR RESPONSES
• My son says they're vaping on the bus
• Need more events for young people
• They are not always at home
• I see that even in pharmacies they sell beer and cigarettes
• I have heard that... sell beer to minors
• We should have more things for good young people. Teens see this and it is not good.

4. ¿qué previene la salud? (barreras)
• El costo de lo que recetan
• El costo de una vacuna en una farmacia

What prevents health? (barriers)
• The cost of what they prescribe
• The cost of a vaccine at a pharmacy

5. Lugares para atención de salud
• St. Lukes
• El Centro de Salud
• Access Health
• Regional Pediatrics—not making referral
• ReGenesis and AccessHealth para acceder cuidado
• Falta de acceso para diálisis para gente sin seguro social
• 13 años—más: difícil de hallar recursos, Charles Lea 3000 niños en listas de espera; el estado no tiene los recursos para autistas y otros problemas
• Tienen que ir hasta Greenville
5. Places for health care

• St. Lukes
• The Health Center
• Access Health
• Regional Pediatrics—not making referral
• Regenesis and Access Health for care
• Lack of access for dialysis for people without social security
• 13 years old—more: difficult to find resources, Charles Lea 3000 children on waiting lists; the state doesn't have the resources for autistic and other problems
• They have to go to Greenville

SALUD MENTAL al otro lado
1. ¿Ha tenido algún problema de salud mental?
   • Partes fáciles
     i. En blanco
   • Difíciles
     i. No seguir estudiando
     ii. No poder entrar a la universidad
     iii. No tener eventos para motivar a jóvenes
     iv. Bullying en las escuelas
   • La depresión por no poder seguir estudiantes, quería irse a México
   • No poder ayudar a los hijos
   • Ayuda en las escuelas para los que no pueden estudiar
   • Grupos para los papás para que pudiéramos identificar ansiedad, depresión etc. Y no simplemente regañar a los hijos
   • Help with bullying for Little kids—sí hay de parte de escuelas, de adolescentes—no
   • Insultos en los buses porque es hispano/a en los buses para escuela de verano
   • Entorno difícil en la escuela de verano
   • Llamarles la atención/ se crean más en un ambiente problemático/educan a los hijos
   • Más información para los padres de la escuela, en español, sobre la crianza para que sean independientes
   • En la escuela hay libertad que no hay en casa
   • Niños traductores no confiables en materia de pasar toda la información
   • Hope/Esperanza clases en Arcadia
     o Odalia
     o Hitka
   • Gestos y risas acerca de castigos
   • ¿Adónde van cuando tienen problemas?
   • Reacción de directores de la escuela es variable
   • Cuidado en familia-mucho amor para tratar la depresión

MENTAL HEALTH on the other side
1. Have you had any mental health problems?
   • Easy parts
     i. Blank
• Difficult
  i. Not continuing to study
  ii. Not being able to enter college
  iii. Having no events to motivate young people
  iv. Bullying in schools
• The depression for not being able to follow students, want to go to Mexico
• Not being able to help children
• Help in schools for which they cannot study
• Groups for dads so we could identify anxiety, depression etc. And don't just scold the children
• Help with bullying for Little kids—yes from schools, from teens—not
• Insults on buses because it is Hispanic on summer school buses
• Difficult environment at summer school
• Attract ingesting them/raise dismay more in a problematic environment/educate children
• Help in schools for which they cannot study
• Groups for dads so we could identify anxiety, depression etc. And don't just scold the children
• Help with bullying for Little kids—yes from schools, from teens—not
• Insults on buses because it is Hispanic on summer school buses
• Difficult environment at summer school
• Attract ingesting them/raise dismay more in a problematic environment/educate children
• Learn more for the school's parents, in Spanish, about parenting to be independent
• There is freedom in school that is not at home
• Children translators unreliable in terms of passing all the information
• Hope/Hope classes in Arcadia
  o Odalia
  o Hitka
• Gestures and laughter about punishments

Where do you go when you have problems?
• Reaction of school principals is variable
• Family care—a lot of love to treat depression

(10) LAST ROUND
1. Lo que está pasando en el país, las parejas que salen a trabajar, los hijos sufren por lo que está pasando, la tristeza y la desesperación cuando no está el papá
   a. Cambio de vida total
   b. Mentiras en las noticias, preocupación de parte de los niños hispanos, aún los nacidos aquí
   c. Cuando son pequeños sufren más, “es algo muy fuerte”
   d. Es duro y largo el proceso
   e. Apoyo psicológico-cómo conversar con los niños que están pasando esto
   f. Terapia y ayuda para los niños
   g. Más atracciones en Spartanburg-cine y mall (es todo)
   h. Saber adónde recurrir, sentirse apoyado
   i. Más pediatras con intérpretes en zonas como Boiling Springs
   j. Programa con información sobre doctores
   k. Una lista de espera, incluso para gente con seguro médico
   l. Hay que programar la enfermedad de un niño de lunes a viernes y llevarlos 2-3 veces para que se les diagostique correctamente su enfermedad

1. What's happening in this county?
The couples who go to work, the children suffer for what's going on, the sadness and despair when the dad is gone
   a. Total life change
   b. Lies in the news, concern on the part of Hispanic children, even those born here
   c. When they are little, they suffer more, "it's a very strong thing"
d. It's hard and a long process

e. Psychological support-how to talk to children who are going through this

f. Therapy and help for children

G. Need more attractions in Spartanburg-cinema and mall (that's it)

h. Knowing where to turn, feeling supported

i. More pediatricians with interpreters in areas such as Boiling Springs

j. Program with information about doctors

k. A waiting list, even for people with health insurance

l. A child's illness must be scheduled from Monday to Friday and taken there 2-3 times to be properly diagnosed with their condition.
Discussion Topics

1. Health Problems/Concerns:
   - Seeing children having general lack of sleep
     - Stay up late playing video games
     - On phone before bed (social media)
     - Do not take naps anymore
     - Major cause of dysfunction, especially at such a young age
   - Mental Health
     - Self-isolation observed as risk for mental health issues.
       ▪ Children/teens find it easier to stay inside rather than have parents worry about them.
       ▪ Do not want to burden parents
     - Adolescents don’t know how to access resources. School/Parents are ill-equipped
       ▪ Turn to peers or social media
     - Anxiety
     - Suicide
     - Anger
       ▪ Often comes from home, anger is transferred from parent to child
   - Social Media/Technology
     - Spend far too much time on
     - Difficult to monitor what children access, especially if parents are working
     - Takes away from personal interactions
     - Concern with effects on mental/behavioral health
   - Sexual Health
     - STIs (Sexually Transmitted Infections)
       ▪ Stigma of getting tested and reaching out for sexual health information/resources, in particular related to homosexual sex
       ▪ Ages 15-24 make up only 27% of sexually active population, but account for 50% of 20 million new STIs per year
       ▪ Kids are abstaining at a higher level, but those that are having sex are at younger ages with higher risk of STIs due to less sexually active group overall (diseases travel more quickly)
     - Having sex before being in relationship as opposed to sex after forming relationship
       ▪ Often found to be harmful to mental health

2. Keeps People from Being Healthy:
   - Poor Eating - Junk Food
     - Often in conjunction with...
   - Not exercising
• Playing video games instead
• Self-Isolation/Fear of surroundings
  o Personal and from parents
• Social Media
  o Lack of supervision
  o Leads to anxiety, affects attitude, false perception of reality
  o Staying up late
  o Bullying/damaged self-image
• Parents
  oParents are not healthy
    ▪ Children pick up these traits because it is what they are used to
    ▪ Normalized Behavior
  oParents are busier
    ▪ Spending less time with children
  oEvolution of not knowing “peopling” skills
    ▪ Parents were latchkey children themselves
• Spartanburg Mental Health
  o Do a great job, but can only treat those with Medicaid
  o Many don’t qualify for help because make too much money, but cannot afford out-of-pocket
• Lack of after-school activities
  o Some do not get physicals, so cannot participate in sports
  o No options other than sports
• Lack of / Inadequate Health Insurance
  oCost of co-pay an issue even with those who have insurance
  o Cannot get dental/optical care

3. Concerns @ Quality
• Mental Health Assessments
  o Especially in rural areas
• Over-prescribing of opioids
  o i.e. Wisdom Teeth
• Communication of available services not done best way to get action
  o All aspects not considered: Cost, effort, change
  o Overwhelming for parents who cannot afford or cannot take time to go doctors’ appointments
• Misdiagnosed ADHD
  o Are not assessing the situation as to why child is acting a certain way
• Inadequate health focus/resources on children
  o SHRS recommends using government services
  o ER cannot handle Mental Health or other emergency for children, send children away
  o No plans for stand-alone ER
• Children’s health is not appropriately prioritized
4. Health/Wellness Resources Missing
   • PPP not used at level it should/could be
   • Resources for parents
     o Especially single mothers
   • Transportation
   • Stand-alone ER for children
   • Adolescent specialist in pediatric practice
   • Lack of faith-based support

5. Health/Wellness Positives
   • Love Notes
     o In high school curriculum as freshman, but could be better used later
     o Teaches creating relationships before sex
   • Sidewalk Hope
     o Provides several resources on sexual health

6. Substance Use
   • Cough Syrup
   • Marijuana
     o Not seen as a drug anymore with the normalization of CBD oil
   • Cigarettes/Jules
   • Alcohol
     o Not just beer, but liquor as well
   • Molly (Ecstasy)
   • Acid making resurgence
   • Whatever is in the liquor cabinet
   • Children seeing drugs in TV/Movies
     o Glamorizes use
   • Children/Teens taking drugs to feel “numb”
     o Change to escape problems facing in life
APPENDIX E. EVIDENCE-BASED WORK GROUP MINUTES (4)

1. Pre-School (ages 0-4)
2. Child (ages 5-12)
3. Adolescent (ages 13-17)
4. Young Adult (ages 18-21+)
1. Pre-School (ages 0-4)

Group Members: Cathy Sparks, Heather Witt, Josie Jones, Lance Feldman, Natalia Swanson, Vern Hayes
Facilitator: Dominique Kokoszka

ISSUES:
- Almost entirely developmental delays with some anxiety or disruptive behavior resulting from
  a) mood disorders b) behavior disorders c) anxiety. Most traced to prenatal use of drugs or alcohol, unstable home situations or intellectual/developmental delays.

EVIDENCE-BASED STRATEGIES:
- Group members mentioned the following practice:
  - **PCIT**: Parent-Child Interaction Therapy, a behavior-based, family-oriented therapy designed to help improve the parent-child relationship through interaction. PCIT is an evidence-based treatment for young children with behavioral problems. PCIT is conducted through "coaching" sessions during which the parent and child are in a playroom while the therapist is in an observation room watching interactions through a one-way mirror and/or live video feed. The therapist provides in-the-moment coaching on parental skills to manage the child's behavior.
  - **Pro**: possibly only EB validated for children under 5 years of age
  - **Con**: from the community standpoint, very time intensive

- Prevention
  - **Play therapy**
    - Focus group member said ages 0-12, Psychology Today says ages 3-12
    - **Goal**: expression and be respectful, while being observed by a therapist
  - **MUSC** has trainings for people who provide services for those aged 0-3

- Early Intervention
  - **First Steps**: Statewide public: private partnership to increase school readiness outcomes for children with developmental disabilities from birth to age 3 and their families. Services include health promotion for young children, parent training: coaching and nurse-family partnerships and childcare provider training. Evidence-based practice to enhance the family and child's learning and development documented with Individualized Family Service Plan outcomes.
    - **Pro**: Prevention, Early Intervention
    - **Con**: Limited to qualifying families with either a diagnosed developmental disability along five (5) quadrants: (1) communication (2) cognition (3) physical (4) social and emotional or (5) self-help and/or with a Downs syndrome diagnosis.

EXISTING PROGRAMS:
- Programs in place right now
  - **Help Me Grow**:
    - Links families to resources for developmentally challenged children
    - State of South Carolina EB
    - [http://helpmegrowsc.org/](http://helpmegrowsc.org/)
Baby Net
- Statewide early intervention services for infants/toddlers with developmental disabilities including play therapy, parent-child intervention and targeted case management.
- BabyNet is South Carolina’s interagency early intervention system for children and toddlers under three years of age with developmental delays, or who have conditions associated with developmental delays.
- Matches special needs of infants and toddlers with development delays to professional resources in community.
- [https://www.scdhhs.gov/resource/babynet](https://www.scdhhs.gov/resource/babynet)

Nurse family partnerships
- Links low-income first-time moms to nursing care
- Group stated this needed to be scaled up first
- [https://www.nursefamilypartnership.org/locations/south-carolina/](https://www.nursefamilypartnership.org/locations/south-carolina/)

Strengthening families
- Provide various services for parental engagement and support
- [https://cssp.org/our-work/project/strengthening-families/](https://cssp.org/our-work/project/strengthening-families/)

Triple P
- Enhances knowledge of parents to prevent developmental issues
- [https://www.connectspartanburg.org/blog/2017/7/25/positive-parenting-program-for-families-in-spartanburg-county](https://www.connectspartanburg.org/blog/2017/7/25/positive-parenting-program-for-families-in-spartanburg-county)

Fostering great ideas in Greenville/Moms Matter, a trademark
- Improving lives of children in foster care
- [https://fgi4kids.org/](https://fgi4kids.org/)

Prevention, Intervention and Postvention:
- Right now, there is a disconnect for this triad in all three settings: school, community, and medical
- The patients seen consist of either parents of kids who think they are behind but aren’t, or parents who think their child is fine, but isn’t
  - Overall: where do we send these kids?

Themes
- Few Evidence-Based programs for babies and toddlers
- Lacking in Whole care model
  - Communication deficits in whole system
  - Inadequate resources
    - How do we get resources into the community?
    - How do we ensure these resources are balanced among the three components of Prevention, Intervention and Postvention?
    - How do we ensure they are Evidence-Based given the lack of certified Evidence Based practices for this young (0-4) age group?
  - Resources aren’t present in the community even when they navigate the system
  - ED:
    - When a child exhibits aggressive behaviors, they are taken to ED
    - Parents or even schools have taken kids since there is no children’s hospitals
      - How do we make sure parents have resources post discharge?
• Not equipped for children under 5
• No child psychiatry consult, so telepsychiatry is the only option
  o 24-hour hold, 2-3 days until released
• Child kept in pod with adult psych patients
• System needs another placement for children
• When applicable, child has case manager with them who must sit with them until a replacement comes in or child receives further instructions
  ▪ Reimbursement for ALL psych visits the same, no matter how time consuming or stressful
  ▪ Result is that clinicians avoid seeing patients that may take more time due to reimbursement
  o There are only 3 facilities for behavioral psychiatry in South Carolina for children under 6 years of age
  o Disconnect between hospital and post-hospital
  o School services don’t start until age 6 and Kindergarten not required in South Carolina
    ▪ Behavioral health very hard to identify at this age
    ▪ Insufficient programs to identify behavioral health issues
    ▪ By the time the child is in school, the developmental delay may have been missed
    ▪ In school, children have lots of eyes on them
    ▪ At this age, when children are learning language, these challenges can be mistaken/missed as developmental delays
    ▪ If in school, since pre-K and Kindergarten aren’t mandatory in South Carolina, these children are typically thrown out, expelled, or taken to the ED
• Gaps
  o Lack of mandatory pre-school programs combined with different composition of school system upon entry (Spartanburg public schools with 7 districts)
  o Chronic non-funding by health insurers of mental health coverage for children under 3.
  o Inadequate knowledge of home resources with reduced funding for Home and Community-Based Services (HCBS)
  o Deficit in Spanish or non-English speaking language facility of providers
    ▪ If hospital could have someone who speaks Spanish available 24/7, ideal
  o Telepsychiatry is the only pediatric option
    ▪ The genuineness of being with a provider isn’t there
  o Gap when parents don’t notice their child’s behavior before school
    ▪ Therapies could’ve been put in place early on
    ▪ This is a statewide problem due to resource allocation
  o Gaps in transportation especially from rural communities
• Questions
  o Where do these parents go?
  o Where does the initial diagnosis happen?
    ▪ Is there a model to follow? Instead of throwing more money at the problem.
2. Child (ages 5-12)

Group Members: Jennifer Parker, Laura Barbas Rhoden, PJ McEnroe, Ruth Schoonover, Trish Beason
Facilitator: Tracy Kulik

ISSUES: Encompasses primarily the Anxiety/Depression and Substance Use issues with less Suicidal ideation. Suicidal ideation an issue for 10-12-year-olds. Mindfulness and impact on Anxiety/ Depression and Adverse Childhood Experiences main issues in Prevention and Intervention.

SETTINGS:
- SCHOOL: Rural residents (District 3) with two family therapists in-school – Richland 2 Districts 2 and 5: School-based counselors
- HEALTHCARE PROVIDERS:
  - Pilot program with therapists embedded at Medical Group of the Carolinas
  - Pilot Year 1 with licensed therapist, 1 pediatrician 2 days (physician referring from Union and Gaffney Counties)

EVIDENCE-BASED STRATEGIES:
- Group members mentioned the following practices:
- Prevention
  - Olweus: Bullying prevention program. OBPP is a whole-school program that has been proven to prevent or reduce bullying throughout a school setting.
    - Pros: prevents or reduces bullying in elementary, middle, and junior high schools (with students ages five to fifteen). OBPP is not a curriculum, but a program that deals with bullying at the schoolwide, classroom, individual, and community levels.
    - Cons: OBPP is not a curriculum, but a program that deals with bullying at the schoolwide, classroom, individual, and community levels.
    - Settings: School and Community
  - Good Behavior Game: Classroom-based behavior management used in elementary schools with instructional curricula. Game format with teams to socialize children to role of student and reduce risks for disruptive behavior including antisocial personality disorder, violence, substance use and suicidal thoughts.
    - Pros: Helps take didactic or lecture out of intervention
    - Cons: Can focus on ‘problem children’
    - Settings: School
  - Intensive Parent Model is a field-based, 12 session practice designed to reduce parental stress and improve child behavior.
    - Pros: Training can be done in 1 day, not time intensive. Current outcomes demonstrate that it reduces parental stress by 25% and child behavior by 33%.
    - Cons: Attendance, compliance by parents
    - Settings: mental health agencies, social service and juvenile justice organizations, schools, and even primary care settings.

- Screening:
  - SBIRT: Screening, Brief Intervention and Referral to Treatment.
    - Mental Fitness helps counselors and school professionals safely identify, screen and refer students to care. This is a collaborative project that connects DMH and other providers into the schools.
  - Settings: Community and School
• Intervention:
  o **CBT**: Cognitive Behavioral Therapy intervention for trauma in schools involves reducing children’s post-traumatic stress disorder symptoms through child, parent and teacher educational sessions. This primarily involves symptoms of anxiety and depression.
    • *Pros*: School-based individual and group intervention ideally resulting in improved function, grades, attendance and peer: parent support.
    • *Cons*: Shown to be less effective with individual coping skills.
  o **TF-CBT** – Trauma Focused Cognitive Behavioral Therapy
  o **RBHS**: RBHS (Rehabilitation Behavioral Health Services) is conducted in tandem with two agencies—the Forrester Center and Spartanburg Area Community Mental Health (DMH) headed by Christian James. RBHS is a school based mental health program headed by an MSW hired by the School District.
    • *Pros*: Popular in school district.
    • *Cons*: None referenced
    • *Settings*: school
  o **Triple P**: Positive Parenting Program. Multi-level parenting and family support system, which aims to prevent childhood behavioral and emotional problems by targeting parents’ behavior. The program focuses on increasing the skills and knowledge of parents as well as enhancing their self-sufficiency and resourcefulness.
    • *Pros*: Triple P found to be effective in research in impacting parenting styles and competency even among Level 4, an intensive training program of 8 – 10 sessions for parents of children with more severe behavioral difficulties. The results indicated that the Triple P Level 4 interventions reduced dysfunctional parenting styles in parents and improved parental competency.
    • *Cons*: Issue for children that are aggressive even at ages 4K–5K, trauma informed care
    • *Settings*: Used by guidance screeners in School even for ESL student
  o **Postvention**:
    ▪ Primary focus on suicide, with appropriate reaction after a dire event.

**EXISTING PROGRAMS:**
• Programs in place right now
  o **Compassionate Schools**:
    ▪ School climate designed to promote trauma-sensitive learning environment based on addressing Adverse Childhood Experiences (ACES) and a trauma informed care model.
    ▪ [https://www.compassionschools.org/program](https://www.compassionschools.org/program)
  o **WRAParound services**
    ▪ In-home, community-based services to prevent out-of-home placement for youth. Interventions include behavior modification, psychosocial rehabilitation and family support.
  o **Strengthening families**
    ▪ Provide various services for parental engagement and support
    ▪ [https://cssp.org/our-work/project/strengthening-families/](https://cssp.org/our-work/project/strengthening-families/)
• Themes
  o Lacking in Whole care model
    ▪ Communication deficits in whole system
    ▪ Inadequate resources
      • How do we get resources into the community?
      • How do we ensure these resources are balanced among Prevention and Intervention?
      • How do we ensure that resources match community need?
  ▪ Resources aren’t present in the community even when they navigate the system
  ▪ ED:
    • When a child exhibits aggressive behaviors, they are taken to ED
    • No child psych consult so telepsychiatry is the only option
      ▪ 24-hour hold, 2-3 days until released
    • Child kept in pod with adult psych patients
    • System needs another placement for children
• Gaps
  o Children referred to Residential placement have issues with return to school
    ▪ Paperwork, Liability concerns, Readiness
  o Child psychiatrist deficit
  o Stigma
  o Spanish or non-English speaking language facility of providers
  o Telepsychiatry as only pediatric option
    ▪ Associated wait times to access this option for initial diagnosis/intervention
  o Funding for services – both reimbursement and issues with adequate resources
  o Finding qualified staff for public service providers given disparity in pay scales with private mental health providers
  o Transportation to services
• Questions
  o If money to overcome issues with Medicaid funding, would all school systems use family therapists in house?
  o Lack of input from Substance Abuse professionals
  o Is issue the children or the parents/ grandparents not understanding the gravity of issues and not knowing how to parent?
  o How to break the cycle of generational acceptance of disruptive behavior?
3. Adolescent (ages 13-17)

Group Members: Alan Eggert, Carey Rothschild, Deb Foreman, Don Mims, Roc Robinson, Sharyn Pittman, Vanessa Thompson, Jamison Smith

Facilitator: Amanda Collins

EVIDENCE-BASED STRATEGIES:
Group members mentioned the following practices:

- **Prevention**
  - **Olweus**: Bullying prevention program. OBPP is a whole-school program that has been proven to prevent or reduce bullying throughout a school setting.
    - **Pros**: prevents or reduces bullying in elementary, middle, and junior high schools (with students ages five to fifteen). OBPP is not a curriculum, but a program that deals with bullying at the schoolwide, classroom, individual, and community levels.
    - **Cons**: OBPP is not a curriculum, but a program that deals with bullying at the schoolwide, classroom, individual, and community levels.
  - **Settings**: School and Community

- **South Carolina Youth Suicide Prevention Initiative**: Initiative to reduce suicide by developing partnerships with community-based organizations, state and local agencies, hospitals, colleges. Programs include Suicide Prevention School-based program, ZeroSuicide program implementation in health and behavioral health settings, postvention counseling.
  - **Pros**: broad program in many diverse settings
  - **Cons**: difficult to customize to needs with focus on assessing maturity not age
  - **Settings**: Community, School, Healthcare

- **Red Ribbon Customized** – Health class in Districts 5 and 7 of the Spartanburg Public School System. Reported by the State – Policy requirement for all middle school students. School Resource Officers (SROs) use.
  - **Intervention**
    - 1 - Assessment / 2 - Referral / 3 - Treatment
    - **Forrester Center Treatment**
      - **Levels**:
        - A) Mild – Decision Making, 4-6 weeks
        - B) Moderate – Decision making + risk of other drugs
        - C) IOP (intensive outpatient program) 8 weeks
      - **Setting**: Medical
    - **CBT**: Cognitive Behavioral Therapy intervention for trauma in schools involves reducing children's post-traumatic stress disorder symptoms through child, parent and teacher educational sessions. This primarily involves symptoms of anxiety and depression.
      - **Pros**: School-based individual and group intervention ideally resulting in improved function, grades, attendance and peer: parent support.
      - **Cons**: Shown to be less effective with individual coping skills.
      - **Setting**: All
o TF-CBT – Trauma Focused Cognitive Behavioral Therapy
  ▪ Pros: Well accepted, strong fit with needs of many students from chaotic households
  ▪ Cons: Considered as first EB strategy, may need a more traditional approach (CBT, RBHS) with more in-depth assessment of emotional trauma history
  ▪ Settings: All

o RBHS: Rehabilitation Behavioral Health Services is conducted in tandem with two agencies—the Forrester Center and Spartanburg Area Community Mental Health (DMH) headed by Christian James. RBHS is a school based mental health program headed by an MSW hired by the School District.
  ▪ Pros: Popular in school district.
  ▪ Cons: None referenced
  ▪ Settings: School

EXISTING PROGRAMS:
Programs in place right now:

• Prevention and Early Intervention
  o Districts 2, 3, 5, 6, and 7 complete assessments and substance use referrals
    ▪ Referrals are immediate if student expresses suicidal ideation or intent to harm
    ▪ Treatment is no more than two weeks.
    ▪ Setting: School

• Intervention:
  o Bridge Program – Bridge Program is a case management program for South Carolina residents (including adolescents) with a confirmed drug addiction facing criminal penalties. This is a cooperative effort between South Carolina’s U.S. District Court, U.S. Probation Office, Federal Public Defender's Office and U.S. Attorney’s Office that provides rehabilitative services to individuals with substance abuse addictions involved in the federal criminal justice system. There are five (5) phases in this program:
    (1) Referral upon evidence of drug addiction
    (2) Probation officer (PO) conducts court interview
    (3) If assessment by PO indicates drug addiction, then contact assigned judge for permission to proceed with assessment process - Refer individual to contract provider of drug assessment
    (4) Prepare summary of probation officer’s evaluation including facts of the case as provided by AUSA and defense counsel; PCRA score\(^{29}\); contract provider’s assessment noting what type of treatment is needed.
    (5) Submit packet to Judge to include summary of probation officer’s evaluation, referral facts, treatment provider’s assessment, assigned Judge’s approval for participation; and program agreement.
  ● Special Needs children are part of this program
  ● Same system used in this Court System (Department of Juvenile Justice, Department of Social Services, Drug Courts)
    ▪ Pros: Presents a policy but not an Evidence-Based intervention

\(^{29}\) PCRA: Post Conviction Risk Assessment
• Cons: May present legal issue for School Resource Officers
• Settings: Court, Schools

- Spartanburg Medical Center’s Emergency Department added recovery coaches to help those struggling with addiction. Three full-time and one part-time peer recovery coaches staff the ER station at Spartanburg Medical Center in shifts from 6 a.m. to 2 a.m., seven days a week. The program started about two weeks ago, making it the third such service in the state. A peer recovery coach embedded in the emergency department is part of a fledgling program run by the Forrester Center for Behavioral Health and Spartanburg Regional Healthcare System.
  • Settings: Schools and Medical

- Postvention:
  Crisis teams to deal with suicide attempts and remainder of student population impacted.

• Themes
  • Spartanburg Emergency Department and inadequate adolescent facility
  • Wait times for access to child or adult psychiatrist and delay in access to telehealth
  • Financial access for student with Medicaid

• Gaps
  
  **Schools**
  • Accessing Forrester Center from the School system for students with substance issues
  • Finance barriers from the community
  • Lack of referrals coming from private schools because they are handled differently.

  **Medical:**
  • Finances
  • Transportation
  • Time – Time affects the financial burden of some families who are already financially burdened.
  • Lack of concern with needs of adolescents, particularly those under 18

• Questions
  • Extent to which mental health and/or substance counselors are embedded in each school district?
4. Young Adult (ages 18-21+)

Group Members: Colin Bauer, Lauren Hulstand, Roger Williams, Sharyn Pittman, Susan Richards, Tom Barnet

Facilitator: Robert Killeen

ISSUES: Encompasses all three (3) areas: Anxiety/Depression, Substance Use issues and Suicidal ideation.

SETTINGS:
- SCHOOL: Late high school or college, workplace or graduated
- HEALTHCARE PROVIDERS:
- COMMUNITY:

EVIDENCE-BASED STRATEGIES:
Group members mentioned the following practices:

- Prevention
  - Olweus: Bullying prevention program. OBPP is a whole-school program that has been proven to prevent or reduce bullying throughout a school setting.
    - Pros: prevents or reduces bullying in elementary, middle, and junior high schools (with students ages five to fifteen). OBPP is not a curriculum, but a program that deals with bullying at the schoolwide, classroom, individual, and community levels.
    - Cons: OBPP is not a curriculum, but a program that deals with bullying at the schoolwide, classroom, individual, and community levels.
  - Settings: School and Community

- South Carolina Youth Suicide Prevention Initiative: Initiative to reduce suicide by developing partnerships with community-based organizations, state and local agencies, hospitals, colleges. Programs include Suicide Prevention School-based program, ZeroSuicide program implementation in health and behavioral health settings, postvention counseling.
  - Pros: broad program in many diverse settings
  - Cons: difficult to customize to needs with focus on assessing maturity not age
  - Settings: Community, School, Healthcare

- Early Intervention
  - Community Support for Young Parents: Statewide program design to support the well-being of teen/very young parents and their families by improving healthy relationships, parenting skills, access to services
    - Pros: Prevention, Early Intervention
    - Cons: Limited to young adult teen parents

- Intervention
  - Family Support Group: NAMI program for support group for caregivers of young adults with mental illness.
  - Family-to-Family: NAMI program providing parent training for families caring for young adults (18-24) with mental health issues.
    - Pros: Individual and group intervention ideally resulting in connecting young adult to services, maintaining care compliance
    - Cons: Legal and compliance issues with compliance
- **CBT**: Cognitive Behavioral Therapy intervention for trauma in schools involves reducing children’s post-traumatic stress disorder symptoms through child, parent and teacher educational sessions. This primarily involves symptoms of anxiety and depression.
  - **Pros**: School-based individual and group intervention ideally resulting in improved function, grades, attendance and peer: parent support.
  - **Cons**: Shown to be less effective with individual coping skills.
- **TF-CBT** – Trauma Focused Cognitive Behavioral Therapy
- **RBHS**: RBHS (Rehabilitation Behavioral Health Services) is conducted in tandem with two agencies—the Forrester Center and Spartanburg Area Community Mental Health (DMH) headed by Christian James. RBHS is a school based mental health program headed by an MSW hired by the School District.
  - **Pros**: Popular in school district.
  - **Cons**: None referenced
  - **Settings**: school

### EXISTING PROGRAMS:
Programs in place right now
- **Prevention**
  - **Out of Their Hands Spring Blitz**:
    - DAODAS annual event in April to strictly enforce drinking laws coupled with strong media messages (substance abuse)
    - State of South Carolina EB
- **Prevention, Intervention and Postvention**:
  - Right now, there is a disconnect for this triad in all three settings: school, community, and medical
    - Issues with disconnected or system-involved youth (DJJ)
    - Prevention aimed at all three issues: anxiety, depression, substance use and suicidal ideation
    - All three vectors involved: prevention, intervention and postvention (suicide)
- **Themes**
  - Age is irrelevant
    - Ages within this group can be at vastly different stage of life
      - Working vs. College
      - Some are married with kids
      - Financially Independent?
    - Do they need services for late adolescents or adults?
      - Those in college may need services for late adolescents, lot of ways more like someone in high school
      - Those working may need services for adults
      - Individual-case specific: depends on where they are in education or life, if they have disabilities, etc.
  - **Lack of Awareness**
    - Not sure what is available for this age group and the services needed
    - Need to expand skill sets of those involved (especially in school setting) to identify issues associated with this age group
Gaps:

- 1st Episode of Psychosis
  - Often presents within this age group
- Transition from schools (High School to College)
  - How will colleges know of issues addressed in high school?
  - Need collaboration
- No treatment if over 18 and not on Medicaid
- Substance Abuse Treatment options
  - What are they?
  - Forrester Center?

Questions

- What are the options for those 18 to 21+?
  - Which is Evidence-Based?
- What are the channels for treatment and support for those presenting as adults vs. those presenting as adolescents?
APPENDIX F: SOUTH CAROLINA EVIDENCE-BASED COMPENDIUM BY AGE GROUP