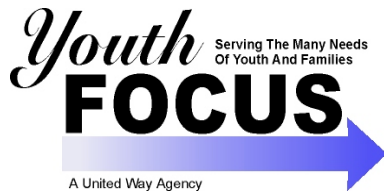


# Mental Health in Guilford County 2006

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## *Overview*

In Fall 2005, the Weaver Foundation awarded a planning grant to a consortium facilitated by the Mental Health Association in Greensboro that included public and not for profit agencies as well as consumers (see members below). Stemming from the first comprehensive health and human service community assessment of Greater Greensboro “Focusing On What Matters,” the Weaver Planning grants were issued in order to facilitate community coalitions and planning around the four focus areas and twelve goals (<http://www.unitedwaygso.org/pdf/FOWM.pdf>).

The Planning Committee focused their proposal on mental health for several reasons. Guilford County and the state are in the midst of Mental Health Reform. Reform will require the Guilford County community to respond effectively to an expanding and increasingly higher-need consumer population in the community. In addition, a greater number of independent providers will potentially be serving individuals, meaning that there is increased risk of duplication and confusion.

Because Mental Health Reform requires active participation of consumers and family members at all levels of decision-making, there is a need for training, information, and opportunities for involvement by consumers and family members. Toward this end, the planning group met, shared information and facilitated two community forums on March 17, 2006 and April 6, 2006 for both providers and consumers of mental health services. Based on input from over 100 community stakeholders as well as a review of local and state databases, the following gaps and asset inventory related to mental health needs and services in the county across the age continuum was prepared. The report provides a current snapshot of the mental health needs and resources in Guilford County. The long-term goal is to distribute the inventory to key stakeholders and the community at large. This information can form the foundation of a community-wide discussion, leading to the prioritization of needs and the development of a strategic plan with regard to sustaining a healthy community.



## *Acknowledgements*

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### **Weaver Mental Health Planning Grant Committee**

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**Blair Benson**  
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*Children's Home Society of NC*

*The Planning Committee gratefully acknowledges the Weaver Foundation for their financial support of this initiative. The Weaver Foundation was founded by W. Herman Weaver and H. Michael Weaver with the intention of supporting activities and causes that benefit the Greater Greensboro area. The mission of the Weaver Foundation is: To help the Greater Greensboro community enhance and improve the quality of life and the economic environment for its citizens while developing a sense of philanthropy, civic education and commitment in current and future generations of the founders' families.*

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## Consumers Served and Current Services

### *Who Is Receiving Services?*

In 2003, The Guilford Center commissioned a report to examine who was accessing services from the Center and their providers (Kane, Farmer, & Shelton, 2004). An analysis of the demographic characteristics of the consumers indicated that most consumers experienced economic challenges with the majority having annual incomes under \$15,000. Because Guilford Center is the primary provider for individuals with Medicaid/Medicare, over three quarters were living below the poverty line. Slightly over half of the adults had a high school education or equivalent. Among younger consumers, boys were more likely to access services than girls at a rate of 2:1 and African Americans were more likely to be served than clients of other ethnicities. Among older consumers (55+ years), women were more likely to access services (60% vs. 40%) and Caucasians were almost twice as likely to be seen as African Americans.

Guilford Center	Number Served	Average Age	Gender	Racial/Ethnic Breakdown	Income Level	% H.S. Education
Total	16,425	30.47	45% Female 54% Male	45% Black; 48% White 1% Asian; .5% Nat.Am.	< \$15K: 90% \$15-25K: 5.8 % > \$25K: 4.2%	N/A
0-8 years	1,428	4.39	38% Female 62% Male	47.7% Black; 38.6% White; 1.5% Asian; .3% Nat. Am.;	<\$15K: 80.4% \$15-25K: 9% >\$25K: 10.6%	N/A
9-17 years	3,328	13.50	37.5% Female 62.5% Male	59.1% Black; 34.7% White; .7% Asian; 6% Native Am.; 3.4% Other	<\$15K: 89% \$15-25K: 6.2% > \$25K: 4.8%	N/A
18-54 years	10,219	35.26	46.8% Female 53.2% Male	42.9% Black; 52.2% White; .5% Asian; .6% Native Am.; 3.3% Other	<\$15K: 91.7% \$15-25K: 5.1% >\$25K: 3.2%	58%
55 and over	1,450	65.87	59.9% Female 40.1% Male	34.8% Black; 62.2% White; .1% Asian;.2% Native Am.; 2.7% Other	<\$15K: 90.7% \$15-25K: 6.8% >\$25K: 2.5%	59.5%

Another source of information as to who is currently accessing services is the North Carolina Treatment Outcomes and Performance System (NC-TOPPS; [www.nctopps.ncdmh.net](http://www.nctopps.ncdmh.net)), a program of the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS). On July 1, 2005, NC-TOPPS became the chief method of collecting information necessary for accountability, quality improvement and management. Information such as consumer demographics, severity of mental health or substance abuse challenge, diagnoses, service needs, barriers to treatment, and level of functioning are captured at baseline, 3-, 6-, 12- month updates, and at discharge. Baseline data from July 1 to December 31, 2005 are available for children (state only), adolescents, adult mental health, and adult substance abuse and starting in July 2006, information will be available from the follow-up assessments.

### **Children Ages 6-11 (Statewide Data Only)**

*Age and Ethnicity:* Similar to the 2003 report from The Guilford Center (Kane et al., 2004), NC-TOPPS data for the state indicates that more males (61%) than females (39%) were served. African American and Caucasian clients were equally likely to be served (approximately 45%) with Latinos representing 6% of clients. The majority of children were 10-11 years old with no clients in the 6-7 year range.

*Health Insurance:* The majority of children had Medicaid (82%), with 6% Health Choice, 8% Private insurance, and 4% having no coverage.

*Severity and Type of Mental Health Challenges:* Half reported moderate severity of symptoms with approximately  $\frac{1}{4}$  indicating mild and severe symptomatology. Of DSM diagnoses, 56% had a diagnosis of Attention-Deficit/Hyperactivity Disorder (AD/HD), 27% Oppositional Defiant Disorder (ODD), 21% Adjustment Disorder, 12% Disruptive Disorder, 6% Post Traumatic Stress Disorder (PTSD), 5% Anxiety Disorder, 5% Bipolar Disorder, and 4% Learning Disorder. Almost  $\frac{1}{3}$  (31%) were physically abused in the last 3 months.

*Educational Achievement:* Most children were doing well with 82% of 6 year olds and 77% of 11 year olds achieving at least C's. However, 14% had had out of school suspension and 1% were expelled. School attendance remains high with over 75% of the age groups attending regularly.



**Adolescents (12-17 years)**

*Age and Ethnicity:* From July 1 to December 31, 2005, 338 adolescents were seen in Guilford County for initial assessments. Of these, 58% were males and 42% females; 57% African Americans, 32% Caucasians, and 4% indicated that they were of Hispanic, Latino, or Spanish origin.

*Health Insurance:* The majority of adolescents were covered by Medicaid (83%), with 3% Health Choice, 9% Private insurance, and 5% having no coverage.

*Severity and Type of Mental Health Challenges:* Forty percent reported moderate severity of symptoms with 25% reporting severe or very severe symptomatology. Of DSM diagnoses, an overwhelming majority had some diagnosis representative of disruptive behavior disorders (e.g., 52% AD/HD; 33% Oppositional Defiant Disorder, 13% Disruptive Disorder, and 12% Conduct Disorder). However, relative to the younger age group, there is a greater percentage of adolescents with internalizing disorders such as Major Depression (23%), with 10% diagnosed with Bipolar Disorder, 9% PTSD, 6% Anxiety disorder and 6% Drug Abuse.

The impact on functioning is seen in consumer ratings on quality of life with 18% rating their physical health as fair or poor; 58% rating emotional well-being as fair or poor and 53% reporting family relationships to be fair or poor. Forty percent report that their symptoms interfere with their activities of daily living on a frequent basis.

*Educational Achievement:* The data show that as consumers move through adolescence, they struggle with educational achievement. Young adolescents were more successful with 92% receiving mostly A's, B's or C's, but this rate drops to 59% and 71% for 16 and 17 year olds, respectively. Most likely, those who are not successful drop out after 16. For example, the average grade level for 16-year-old consumers is 9.9, with only 77% of 12-17 year olds enrolled in any academic program and of those, 7% are in alternative learning programs and 1% in a GED program. Over one-quarter had out of school suspension (27%) and school attendance drops from 76% among 12 year olds to 47% for 17 year olds.

*Other Risk Factors:* Of the adolescent consumers, 1% were involved in the adult correctional system, 21% were under juvenile correctional

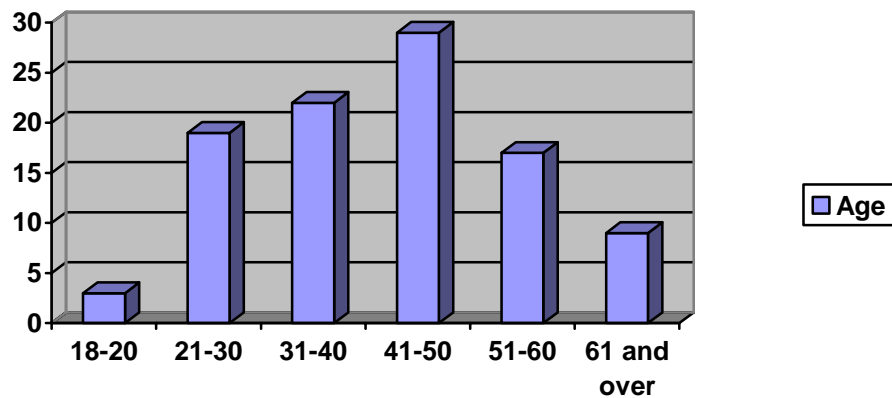


supervision, and 16% were required by the juvenile justice system to receive services. When examining arrest history, 7% had a history of felony arrests with 24% having misdemeanor arrests. Substance use increases with 20% reporting use of tobacco in the past 12 months; 8% alcohol, 17% marijuana, and 1% other substances (e.g., cocaine). 3.3% have children of their own compared to 1.9% statewide.

*Living Situation:* Among adolescents served in Guilford County, 77% lived with a family member or a guardian (e.g., 15% were in foster care). 15% were in residential programs but none was identified as homeless.

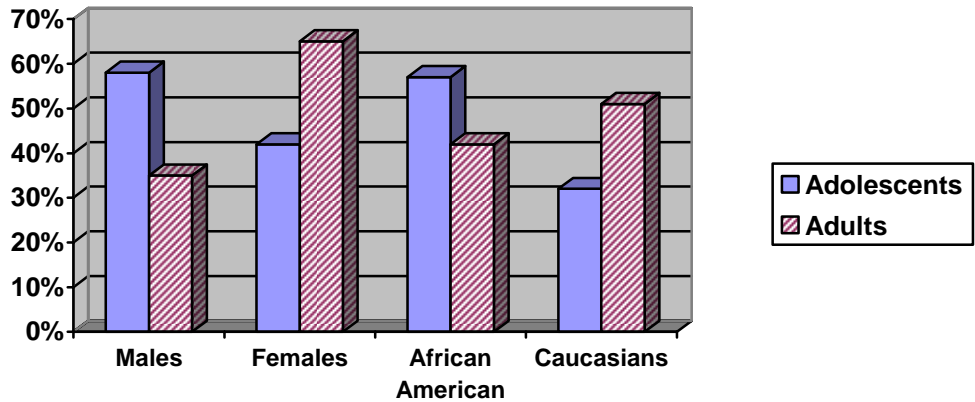
### Adult Mental Health Consumers (18 years and Older)

*Age and Ethnicity:* From July 1 to December 31, 2005, 1,794 adult consumers were seen for initial assessments for mental health issues. The majority (70%) were 21 to 50 year olds. Only 3% were 18 to 20 year olds and only 9% were 61 and over.



The ratio of males to females and ethnic/racial breakdown among adults is almost completely opposite to the demographics among adolescents with 35% males and 65% females served and 42% African Americans, 51% Caucasians, and 4% indicated that they were of Hispanic, Latino, or Spanish origin. In examining possible explanations for these trends, other research on the disproportionate representation of youth of color in our correctional systems as well as trends in substance abuse treatment would suggest that many of the young African American male or male consumers are either in the correctional system and/or are being served primarily in substance abuse treatment and therefore do not show up in these numbers (NC-TOPPS).

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*Health Insurance:* Insurance becomes an even greater challenge for adults. While 40% continue to have Medicaid and 26% have Medicare, only 2% have Private insurance, and 42% report having no coverage.<sup>1</sup>

*Severity and Type of Mental Health Challenges:* Regarding severity of symptoms in the last month, responses were fairly evenly divided between severe or very severe (36%) and moderate (35%). However, relative to adolescents, the majority indicated that their quality of life was only fair to poor (e.g., 56% physical health, 70% emotional well being; 52% family relationships) and 46% indicated that their symptoms interfered with daily life on a regular basis.

Of DSM diagnoses, relative to adolescents, the primary diagnoses were more internalizing than disruptive or externalizing (e.g., 46% Major Depression, 26% Schizophrenia, 14% Bipolar, 12% Anxiety Disorder and 6% PTSD). 4-6% reported challenges with substance use in addition to mental health challenges (see next section for information on adults accessing substance abuse services). Almost one-quarter report being sexually abused and one-third reported suicidal thoughts.

*Educational Achievement and Employment:* Of the adult consumers, 33% did not graduate from high school; 29% had a HS diploma or GED; with only 36% have some college. Only 24% were employed full-time, 31% employed part-time, and almost half (45%) were unemployed but seeking work.

<sup>1</sup> Due to multiple responses, does not equal 100%

*Other Risk Factors:* Thirty percent had misdemeanor arrest with 13% reporting some felony arrest. 2% reported contact with Department of Social Services (DSS) regarding child abuse/neglect in the last year. 61% had custody of all their children, but 32% had custody of none of their children. For those reporting substance use, 49% reported using tobacco (24% of these smoke a pack a day or more), 26% reporting alcohol to heavy alcohol use, 9% marijuana, 7% cocaine, and 3-5% reporting using other opiates, heroin, over-the-counter or other substances such as Benzodiazepine or Oxycontin.

*Living Situation:* Among adult consumers, 75% lived in a private residence, 5% were in an institution or facility, 3% were in residential programs but 6% were in temporary housing and 3% were homeless. Of these 3% homeless, only half were in shelters. With regard to marital status, 43% were divorced/widowed/separated, 38% never married, and only 19% married or living with a significant other.

### **Adult Substance Abuse Consumers (18 years and Older)**

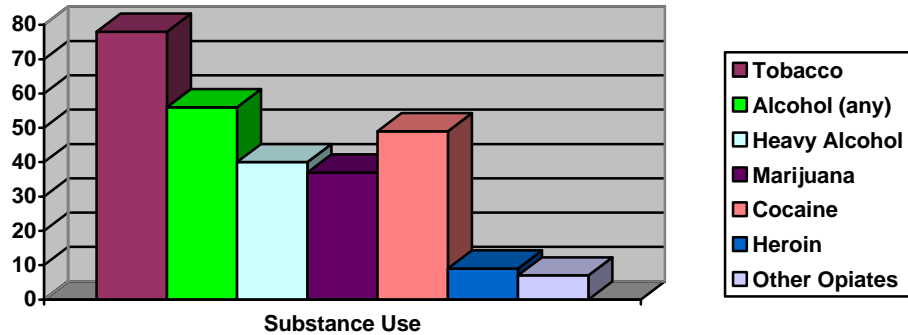
*Age and Ethnicity:* From 7/1-12/31/05, 526 adult consumers were seen for initial assessments for substance abuse issues. Relative to mental health, more males (60%) than females (40%) were seen with a fairly even distribution by race/ethnicity (i.e., White/Caucasian 51%, African American 46% and 1% indicating that they were of Hispanic, Latino, or Spanish origin). Similar to mental health services, the majority of substance abuse consumers (87%) were in the 21 to 50 year age group.

*Health Insurance:* Consumers of substance abuse services have major challenges with regard to health insurance. Only 16% have Medicaid, 4% with Medicare, 4% Private and 75% have no coverage.

*Severity and Type of Mental Health Challenges:* In contrast to adults accessing mental health services, adults with a substance abuse diagnosis reported that their mental health symptoms were relatively mild (61%) and only 19% reporting severe symptoms. However, their ratings of quality of life were still high with 54% rating physical health, 66% rating emotional well-being, and 62% rating family relationships as fair to poor. 40% reported symptoms interfering with daily life on a regular basis. Of DSM diagnoses, 74% were drug dependence, 45% alcohol dependence, 15% drug abuse, 11% alcohol abuse. 16% also had a diagnosis of Major Depression, 11% Bipolar Disorder, 6% Anxiety Disorder, 4% Schizophrenia, 3% Post Traumatic Stress Disorder, and 2% Personality Disorder. 15% reported physical abuse in the past 3 months and 18% reported some history of sexual abuse. Over one-quarter (27%) reported suicidal thoughts.

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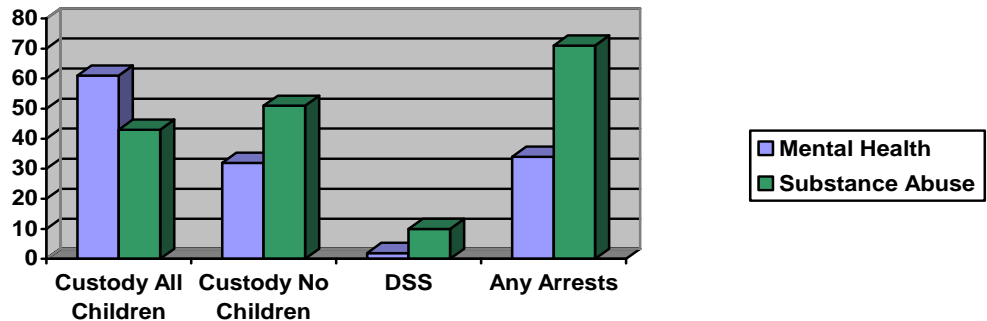
Self-reported substance use for the past 3 months were as follows.



*Educational Achievement and Employment:* Of adult consumers, 32% did not graduate from high school; 40% had a HS diploma or GED; with 28% having some college. Only 28% were employed full-time, 23% employed part-time, and almost half (49%) were unemployed but seeking work.

*Other Risk Factors:* Relative to adults accessing mental health services, adults with substance abuse challenges were more likely to be involved with the legal and social services (DSS) system. More specifically, there were almost twice as many with misdemeanor arrests (65% vs. 30%) and almost three times as many with felony arrests (37% vs. 13%) for consumers of substance abuse treatment as mental health consumers.

Five times as many consumers with a substance abuse diagnosis reported contact with social services regarding child abuse/neglect in the last year (10% vs. 2%). Only 43% had custody of all their children, with 51% having custody of none of their children.



*Living Situation:* Among adult consumers, 73% lived in a private residence, 5% were in an institution or facility, 3% were in residential programs but 7% were in temporary housing and 9% (relative to 3% for adults accessing mental health services) were homeless. Of the homeless, only half were in shelters. With regard to marital status, 40% were divorced/widowed/separated, 44% never married, and only 17% married or living with a significant other.

Similar findings have been identified through the comprehensive surveys conducted by the Guilford County Substance Abuse Coalition. The comprehensiveness of the substance abuse challenge is reflected in one of their reports highlighting that in 2001, over 40,000 Guilford County residents were addicted with over 200,000 individuals impacted by this addiction.

### *What Services Are Being Provided?*

Follow-up data from NC-TOPPS ([www.nctopps.ncdmh.net](http://www.nctopps.ncdmh.net)) available after June 30, 2006 will provide more detailed data about the services that were provided. However, in examining the baseline data, some information is available about IPRS (Integrated Payment and Reporting System) target population categories utilization of special program services.

### **Adolescents (12-17)**

Among adolescents, 8% were receiving Intensive In Home, 3% were receiving Multisystemic therapy. 7% were classified as sexually aggressive and 5% as sexual offender. 51% were classified as serious emotionally disturbed and 39% as seriously emotionally disturbed with out of home placement.

### **Adult Mental Health**

Among adults, 29% were receiving Medical management; 1% were receiving Assertive Community Treatment (ACT); none received psychosocial rehabilitation; 67% were classified as having serious mental illness with 28% reported as having persistent serious mental illness; 2% were classified as adult substance abuse high management.



### **Adult Substance Abuse**

Among adults whose primary presenting issue was substance abuse, 58% were classified as adult substance abuse high management; 21% were classified as having injection drug use with a communicable disease; 17% were criminal justice offender, 17% were described as homeless, 15% were receiving methadone treatment; 13% were involved with TASC (treatment accountability for safer communities), 4% were receiving medical management; 1% were in a jail diversion program; 1% received ACT; 1% received CST (community support team) and none received psychosocial rehabilitation.

## **Consumers Likely to Need Services**

Based on projections from US Census data as well as projections from epidemiological studies examining expected numbers of individuals with mental health and substance abuse challenges (Kane et al., 2004), there are approximately 80,000 to 92,500 individuals across the age range who potentially are in need of services. By 2010, this will likely increase to 85,500 to approximately 98,000 individuals within Guilford County.

Looking at other trends and local and national research, who these individuals are likely to be becomes clearer.

### **Individuals with Economic Challenges**

Either because of economic stresses and/or a result of their mental illness or substance abuse, individuals with economic disadvantage are more likely to be in need of mental health and substance abuse services. This is evident in the data of those currently being served and is supported through research. For example, higher numbers of both children and adults who live below the poverty level report having mental and emotional difficulties and functional limitations. More specifically, almost 1 in 5 individuals receiving welfare meet criteria for a DSM diagnosis. Almost 50% of those applying for welfare could be diagnosed with Depression, 7.3% with Generalized Anxiety Disorder, and 9.2% with Panic Disorder.



Mothers living in poverty, particularly mothers of young children, are consistently identified as needing supportive mental health services (Rosen et al., 2003). Furthermore, over 90% of adults with serious or persistent mental health disorders are unemployed (NIDA, 1992) which creates other challenges particularly with regard to health insurance. Children living in economic disadvantage are also at increased risk for both internalizing (e.g., anxiety) and externalizing disorders (e.g., oppositional defiance) (Briggs-Gowan et al., 2001; Hauquing Qi & Kaiser, 2003; Keenan et al., 1997).

Given the association between economic challenges and need for mental health and substance abuse services, what we expect based on the economic indicators in Guilford County?

- 25% of Greensboro families could not afford a 2 bedroom apartment in 2002.
- 90% of heads of household in public housing were single females with an average income of \$6,677 (United Way, 2002)
- 23% of single mother households are living below the poverty level. (US Census, 2000)
- Greensboro/High Point unemployment rate was 5.1% (12/05; UNCG's Bryan School of Business)
- In 2003, 11.6% of children ages 0-17 and 20.3% of adults ages 18-64 are uninsured in Guilford County (UNC Center for Health Services Research)
- In 2004, the Piedmont Triad Council of Governments reported 53,139 individuals in Guilford County were without health insurance (<http://www.ptcog.org/noinsurance.html>). By 2006, this number had increased to approximately 66,000 uninsured (News and Record, 2/19/06).

## Homeless

U.S. Department of Housing and Urban Development (HUD) cites the lack of affordable housing, untreated mental illness, and untreated substance abuse as the top three reasons for homelessness. It is estimated that 1/2 of homeless adults have mental disorders, 2/3 have alcohol use disorders, and just under one-half have drug use disorders (Fischer, 1989). Other research highlight the overlap between homelessness and mental health and substance abuse risk.



- Poverty, inadequate housing, and disabilities that prevent employment all contribute to homelessness. Although almost half of homeless individuals work at least part-time, their average monthly income is only \$367, which clearly limits housing options. Those receiving SSI, which were \$545 per month in 2002, also struggle with finding affordable housing (NRCHMI, 2004).
- Single women with children have shown a rapid increase in their rates of homelessness (Fisher & Breakey, 1991; Jackson, 2004). 11% of those affected by homelessness are parents with children, 84% of whom are single women and 23% of homeless individuals are children under 18 with a parent, almost half of which are under the age of 5 (NRCHMI, 2004).
- Although African Americans comprise 12% of the US population, they comprise almost 40% of the homeless population (U.S. DHHS, 2001).

As is evident in the review of the NC-TOPPS data, these trends apply to Guilford County where individuals with mental illness and who have substance abuse are more likely to be homeless than those without those challenges. Guilford County's Homeless Prevention Coalition completed a Point in Time count of homeless (using HUD criteria) on 1/25/06 (<http://www.hpcgc.org/Get%20Facts/statistics.asp>) and found 1108 individuals who were homeless. An additional 839 (151 of whom were high school students) students were identified by Guilford County Schools. These numbers represent an increase of 73% for HUD and 52% for GCS over the previous estimates. An additional 90 were identified through other sources. Conservatively, there are over 2,000 homeless individuals within Guilford County, many of whom will have serious mental health and substance abuse challenges and most of whom will have little insurance.

Another challenge has been the closing of inpatient facilities. From 2001 to 2004, NC has closed 441 of its state psychiatric beds. Many of these individuals have no home so 1140 patients were sent to homeless shelters at discharge. (Winston-Salem Journal – 2/5/06)

## Children

Although research has shown that mental health challenges can develop early in life, there often is resistance to accept this finding (Carter, 2004) due to an emphasis on cognitive, motor, and language development as well as the stigma of mental health. Nevertheless, there is increasing evidence that young children may be experiencing significant challenges with social emotional development. For example, Lavigne et al. (1996) found that 21% of 2-5 year olds were likely to have a DSM disorder, and almost half of those exhibited severe symptoms. Carter (2004) noted that 7-24% of parents report that their young children have social/emotional problems. 10% of 1-2 year olds that completed a developmental screening had significant behavioral problems and 37% of 18-month olds still had these problems at 30 months.

Difficulty developing positive relationships with caregivers, lower intelligence, slow language development, and lower social skills are all associated with higher prevalence of behavior disorders. In addition, higher parental stress, lower parental education, lower social support, and harsh discipline are risk factors for behavioral problems in preschool children. High family conflict and community violence may also raise the likelihood of behavior problems.

Of particular concern are the children in foster care. In 2005, there were 552 children in foster care in Guilford County. Depending on the reason for the placement, these children are likely to be at higher risk for emotional and behavioral disorders (Chapin Hall for Center for review; [www.chapinhall.org](http://www.chapinhall.org)).

Among adolescents, substance abuse prevention and treatment services will continue to be a need. The Guilford County Schools Youth Risk Behavior Survey (2003) reported that 13% of middle school students and 41.4% of high school students are current users of alcohol and that 4.8% of middle school students and 25.2% of high school students are current users of marijuana. Additionally, 14.8 % of middle school students and 37.2% of high school students were offered, sold, or given illegal drugs on school property in the past. Similar trends were found across NC as evidenced below.



**Substance Abuse Use Among NC High School Students 2003**

Substance	Males	Females	African Amer/Blacks	Latinos/Hispanics	Whites
Marijuana	42.3	38.2	42.7	44.0	39.3
Inhalants	13.8	13.5	7.6	16.0	16.5
Methamphetamine	8.3	7.3	2.1	13.5	10.0
Cocaine	7.1	6.2	2.3	10.6	8.4
Steroids	6.5	3.5	3.4	12.8	5.3
Heroin	3.1	1.4	1.3	5.8	2.5
Injection	2.6	1.2	1.0	5.0	2.0

In terms of Guilford County, the following statistics highlight the need for attending to our youngest residents when planning mental health services.

- In 2004, Guilford County had 446 substantiated cases of abuse and neglect. (Annie E. Casey Foundation)
- In 2005, there were 552 children in Guilford County in foster care (compared to 9,820 statewide) (North Carolina Child Advocacy Institute; NCCAI)
- In 2004, 1,541 juveniles had complaints with 24 committed to Youth Development Centers (i.e., juvenile detention centers) in Guilford County (NCCAI)
- In 2002, there were 178 births to teenage mothers aged 15-17 (NCCAI)
- In 2003, there were 33,202 children aged 0-5. Of these, 20.1% lived below the poverty level (NCCAI)



- In 2004, 18.4% lived in families receiving food stamps; 26.2% lived in single-parent families; 31.1% are enrolled in Medicaid and 4.5% enrolled in NC Health Choice program; 2,053 children were reported as abused and/or neglected and 736 of the cases were substantiated. 35.2% of children aged 0-4 were enrolled in regulated child care programs and of these only 8% were Five Star Programs (highest licensure grade in NC).
- Based on epidemiological studies, referral rates, and census data, there are approximately 5,000 children birth to five that potentially are in need of services to address serious challenges in social emotional development.

## **Young Adults**

Another potential group that needs special attention are those young adults ages 18-25. Because many services are tied to categorical criteria such as age, young adults may find that they are too old for services for youth and yet not meet criteria for services for adults. It is also difficult to track this age because many research studies as well as tracking systems tend to group young adults within the adult population.

Forums led by the Chapin Hall Center for Children at the University of Chicago (<http://www.about.chapinhall.org/conferences/conferences.html>) highlight the special challenges for this age group. Academic failure, unemployment, and underemployment are high, particularly among those who have been in foster care. Upon adulthood, many of these youth must navigate completely new service systems, often without any adult guidance or support. Even when services are available, health insurance is often an issue particularly if the young adult is not living with their parents.

These challenges are reflected in the NC-TOPPS data where only 3% of adults served for mental health challenges were 18 to 20 year olds. Similarly, Guilford County DSS reported that from 7/05 until 3/06, 23 youth “aged out” of DSS system. Of these, only 6 were still in school; only 7 had stable housing (Department of Social Services Report to Guilford County Community Collaborative, 3/13/06).



### Older Adults

Demographic trends across the US and NC suggest that there are likely to be increasing numbers of older adults in Guilford County.

- 20% of Greensboro's population (43,648) in 2003 was 55 years of older (City of Greensboro City Data Book, 2003) and the NC Division of Aging predicts a 25% increase over the next 10 years.
- Approximately 28% of Guilford County's adults ages 65 and above live alone and 62.9% live with relatives (Piedmont Triad Council of Governments; PTCOG; <http://www.ptcog.org/census.html>)

Population of Adults Ages 65 and Above Living Alone	14,072 (28.4%)
Population of Adults Ages 65 and Above Living With Another Individual in a Group Setting	35,404 (71.6%)
Population of Institutionalized Adults Ages 65 and Above	2,312 (4.7%)

Other indicators highlight the increased risk that older adults have for mental health challenges.

For example,

- 8-20% of older adults in communities and up to 37% who receive care in a primary care settings experience depression (US DHHS, 1999).
- Clinically significant depression in older adults is higher in those who are bereaved or those living with a chronic illness (e.g., heart disease, cancer, arthritis, Alzheimer's, etc.) (US DHHS, 1999).
- Older adults are often more likely to seek treatment from their primary care doctors. However, only a small percentage of primary care physicians report feeling comfortable diagnosing and treating depression in older adults resulting in disorders going unrecognized and/or untreated (Callahan et al.,1992; Rabins, 1996).
- Of those 65 years of age and older experiencing a mental disorder, an estimated 2/3 are not receiving needed mental health services (Rabins, 1996).



- More than 3,263 older adults in Guilford County are diagnosed with Alzheimer's disease and of these, 1,942 have moderate to severe needs and cannot be left alone unsupervised (NC Division of Aging, NC State Data Center, 2003).
- 42.4% of Guilford County's civilian noninstitutionalized adults ages 65 and above have a disability (United Way, Focusing on What Matters)

Economic challenges are also evident among older adults, which impact their ability to access needed services. For example,

- 12.7% of adults ages 65 in NC live in poverty.
- 10% of Greensboro's residents 60 years and above live below the poverty level (NC Division of Aging, NC State Data Center)
- 17% of those 65 years and above that live alone are without transportation (Area Agency on Aging, Piedmont Triad Council of Governments, 2002).
- Households containing families headed by persons 65+ reported a median income in 2000 of \$32,854 (\$33,467 for Whites, \$27,952 for African-Americans, and \$24,330 for Hispanics). About one of every eight (12.1%) family households with an elderly householder had incomes less than \$15,000 and 46.8% had incomes of \$35,000 or more (Administration on Aging: Profile of Older Americans, 2001).

Thus, the number of older adults is increasing and it is likely that as this population increases, the need for services that address those conditions likely to affect older adults will increase (i.e., including dementia, depression, symptoms associated with Alzheimer's, and those that accompany health problems such as cardiac conditions and other disabilities).



## Services Needed and Identified Gaps

These trends and current usage provide insight as to services likely to be needed. In addition, NC-TOPPS ([www.nctopps.ncdmh.net](http://www.nctopps.ncdmh.net)) data, several local surveys as well as the responses from the Provider and Consumer Forums conducted in March-April 2006 provide further data about service needs.

### NC-TOPPS Data

The following are the service needs rated as being “very important” by adolescents and their caregivers, adult mental health, and adult substance abuse.

<i>Service Need</i>	<i>Adolescents</i>	<i>Adult Mental Health</i>	<i>Adult Substance Abuse</i>
Appropriate Living Setting	32%	22%	34%
Crisis Services	24%	12%	20%
Educational	24%	56%	29%
Emotional Care	75%	64%	49%
Family/Peer Relationships	40%	57%	38%
Finances	32%	4%	27%
Food	40%	22%	41%
Housing	38%	17%	39%
Job	31%	1%	52%
Legal	14%	14%	27%
Medical	53%	31%	36%
Transportation	38%	20%	41%

Respondents were also asked to identify barriers to treatment. Keeping in mind that these were consumers accessing treatment before full divestiture of services from The Guilford Center, the following barriers were identified.

<b>Barriers</b>	<b>Adolescents</b>	<b>Adult Mental Health</b>	<b>Adult Substance Abuse</b>
Child Care	1%	1%	2%
Cost	3%	15%	10%
Health Problems	2%	4%	2%
Scheduling	4%	4%	4%
Service Location	0%	1%	2%
Transportation	7%	11%	11%
Waiting List	0%	1%	2%
No Barriers	82%	69%	76%

### **Guilford County Youth Provider Survey**

A survey completed in Fall 2005 with input from The Guilford Center, Youth Focus, Guilford County Schools, and Juvenile Justice examining rank ordering of general preventive services, interventions, and treatments relative to 3 questions: (1) How much is the service needed? (2) How available is the service? and (3) How accessible is the service?

The most frequent services requested included:

- *Educational services, public school support services, alternative schooling, and tutoring*
- *Transportation*
- *Outreach*
- *Community based services and outpatient counseling*
- *DSS services*
- *Family preservation*

When a service was available, it was generally rated as accessible, but there was a perceived gap between need and availability, particularly with regard to the services mentioned above.



### **Provider Forum**

In the provider forum organized by this project on March 17, 2006, the following themes were identified as critical factors/potential barriers with regarding to meeting service needs.

- *Availability of providers*
- *Qualifications and skills of providers*
- *Affordability and accessibility of services*
- *Community support*
- *Transition and coordination of services*
- *Training and education of providers and consumers*

In the small group discussions, these issues were further refined with the following themes identified.

*Availability of Providers, Particularly Psychiatrists and other Physicians to Support Mental Health/Substance Abuse Services Needs*

Many were concerned about the limited availability of psychiatric services, especially for children. A related concern was both the over and under prescription of psychotropic medications.

These concerns are supported by data in a recent survey that indicated a severe shortage of psychiatrists in NC. More specifically, 44 counties have a severe shortage and 43 counties have no child psychiatrists ([http://www.shepscenter.unc.edu/hp/Psychiatrist\\_Brief.pdf](http://www.shepscenter.unc.edu/hp/Psychiatrist_Brief.pdf)). Guilford County fell into the category that had .60 to .98 full time equivalent (FTE) per 10,000 residents and less than 1 child psychiatrist at the time of this report.

*Availability of Services for Older Adults*

Given the findings that most older adults will consult a health care professional about mental health concerns, the research that indicates that many physicians feel uncomfortable managing these concerns and medications, and the projected increase in the numbers of Guilford County residents over 55 years (Piedmont Triad Council of Governments; <http://www.ptcog.org/age04.htm>), another concern was the degree to which there will be sufficient medical staff, trained in both geriatrics as well



as mental health issues to address the growing population of older adults in our community. Other issues relate to the need for mental health professionals who have training in geriatrics as well as concerns about the availability of funding of treatment services for older adults given the high percentage who have economic challenges.

### *Trained Professionals that Are Culturally and Linguistically Diverse*

Another concern raised in the forum was the lack of mental health professionals that reflect the growing racial and ethnic diversity in Guilford County. Two-thirds of substance abuse providers in a recent study reported that services for Latinos were inadequate and only 1 out of 3 treatment centers reported that they had at least one counselor who spoke Spanish (NC Governor's Institute on Alcohol and Substance Abuse, NC Latino Project, 2002). There are 97 different languages spoken in Guilford County schools (see 2004 report by UNCG's Center for New North Carolinians (<http://cnnc.uncg.edu/>) and in Guilford County, the residents reporting that they did not speak English "very well" increased from 1.6% in 1990 to 4.6% in 2000 (<http://www.ptcog.org/language.htm>). While there are approximately 5% of Guilford County's population that are Hispanic or Latino, according to 2005 NC-TOPPS data only 1% of those served were Hispanic/Latino. Similar trends were reported in the 2003 Guilford Prevalence and Penetration Study (Kane et al., 2004).

These trends highlight the need for services that are culturally competent, that address the needs of individuals for whom English is not a primary language, more multilingual providers, information and resources translated into multiple languages and more interpreters.

### *Affordability and Accessibility of Services*

Several comments related to concerns about funding particularly with regard to mental health reform. In 2000, there were an estimated 12.8% of individuals in Guilford County without health insurance coverage and 10.5% of children under 18 were without covered (Piedmont Council of Governments; <http://www.ptcog.org/noinsurance.html>). In addition, as was evident from the NC-TOPPS data and the 2003 Guilford Center report as well as from research, individuals with economic challenges will continue to be more highly represented among those accessing services. Historically, The Guilford Center has been the primary service provider for those with Medicaid and other economic challenges.

However, concerns were addressed given the large numbers of adults without any coverage (e.g., over 40% of adults) and full divestiture from



The Guilford Center, whether community providers will be willing and able to provide appropriate and comprehensive treatment.

Community Support Issues

Similar to NC-TOPPS data, providers identified several community supports that need to be expanded in order to provide comprehensive services. These included: transportation, housing, employment, respite care and other supports for the family of the individual with mental health needs.

Transition/Coordination Issues

Many were concerned about providing comprehensive services for individuals that were in transition such as youth aging out of the system, individuals returning to community from hospitalization to homeless shelters, and better collaboration across the various systems for consumers whose needs might cut across systems such as developmental disabilities, substance abuse, mental health, and the schools.

Training/Education Issues

The need for ongoing training for providers, for professionals in non-mental health settings like to serve individuals with mental health or substance abuse challenges (e.g., homeless shelters) and for consumers also was mentioned. Training issues included:

- *How to work effectively with older adults*
- *How to provide culturally competent services*
- *Knowledge of empirically-based treatments*
- *Working effectively in partnership with consumers*
- *How to use peer-to-peer/consumer support effectively*
- *How to access services and providers (especially with divestiture from The Guilford Center)*

## Consumer Forum

Similar to the March 17, 2006 forum, a forum for consumers was held on April 6, 2006 where participants were asked to identify the most critical factors/potential barriers to meeting service needs. The following were the most frequently mentioned factors:

- *Funding for services*
- *Reducing the stigma for seeking help*
- *Accessibility and awareness of services that are available*
- *Need for elected officials to be aware of need*
- *Need for the legal system, such as judges, law enforcement, to help with accessibility*
- *Increased mental health services in the schools*

In the small group discussions, participants were asked the following questions.

*What are the 3 most important services that are available in our community?*

Respondents tended to identify an array of community supports such as the Mental Health Association, peer support services, Compeer, National Alliance for the Mentally Ill Helpline, Sanctuary House – Club House, free counseling provided by Family Service of the Piedmont, SCAT (transportation) as well as the private providers, psychiatric services when available and Medicaid providers.

*How difficult is it to access them?*

There was a range of responses with some indicating that community supports were easy to access if you had an *advocate* and met eligibility criteria but others indicating that a *lack of awareness* made it difficult and sometimes these services were underutilized. Many mentioned that it was difficult to access professional services due to limited Medicaid practitioners, particularly psychiatrists, and the difficulty in accessing private providers without insurance.

*What are Barriers to accessing them?*

Barriers mentioned were similar to the provider forum and information on the NC-TOPPS. Frequently cited barriers included:

- *Funding (insurance, Medicaid)*
- *Transportation*
- *Divestiture and reduction in services*



- *Divestiture and lack of knowledge about how to access services and available providers*
- *Stigma*
- *Shortage of trained volunteers; shortage of advocates*
- *Long waiting lists particularly mental health/substance abuse providers*
- *Limited coordination between agencies and lack of follow-up services or transition services to community*

*If a service is not available or limited, what are the top priorities for needed services?*

Most frequently cited services included:

- *Transportation*
- *Quality long-term psychiatric care*
- *Increased community awareness of needs*
- *Affordable housing/sheltered housing*
- *Community based services such as school-based and home-based*

## Summary and Recommendations

A review of the various sources of information (e.g., 2003 Guilford Center report, 2005 NC-TOPPS baseline data, Provider and Consumer forums, demographic trends, and research literature) provides a fairly consistent picture of the state of the mental health system in Guilford County.

### Service Needs

Guilford County will continue to need a continuum of care in order to provide a healthy and supportive community for all residents.

- There is a need for continuum of inpatient and outpatient services for residents across the age range. In addition, the following specific recommendations are made:
  - Increase the number of psychiatrists, particularly child psychiatrists, and other physicians (e.g., family practice) who can support mental health and medication needs



- Increase the availability and accessibility of a full range of substance abuse prevention and treatment services for all ages but with particular attention to the coordination of services from inpatient to outpatient and to the needs of adolescents
- Increase the number of providers who are linguistically and culturally competent
- Increase the number of qualified Medicaid providers willing to serve consumers, especially those consumers with severe mental health and substance abuse challenges
- Increase the number of providers skilled in serving older adults
- Increase the availability of crisis care and coordinated inpatient and outpatient psychiatric services)
- There is a need for a complementary continuum of informal supports and community based services including the following:
  - Increase the availability and use of peer and family support
  - Increase the number of trained consumer advocates and the willingness and skill among providers to use this resource
  - Increase information about available services and how to access them

## **Barriers**

A number of barriers/concerns were identified as well. The most frequent across the various sources included:

- Need for increased funding all services with particular concern for the uninsured and those without private insurance
- Limited number of qualified Medicaid providers
- Transportation
- Stigma

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- Lack of awareness of available services and how to access them
  - Lack of coordination across providers, between agencies, among formal and informal supports
  - Lack of professional awareness of and funding for consumer support efforts (e.g., peer support, family advocates)

## **Recommendations**

Based on this report, the project planning committee recommends the following.

- Several key indicators of quality mental health services should be identified and tracked. NC-TOPPS follow-up data will provide one point of reference but these indicators need to be summarized and shared with the community on a regular basis.
- Community needs should be re-evaluated in January 2008 and every two years thereafter. This study provides a good baseline as Guilford moves into full divestiture in mental health reform and can provide some guidance as to the range of providers and informal supports that are needed as well as to guide education/training (e.g., Area Health Education Center offerings) and workforce development activities within the Triad and the institutions of higher learning.
- Similarly, there needs to be some mechanism for reviewing this information and informing not only the general public but policy stakeholders as well (e.g., elected officials). There are several possible organizations/coalitions that could serve this function (e.g., Mental Health Association, Guilford Community Partners, Guilford County Collaborative, Guilford County Substance Abuse Coalition, NAMI) but it will be important for there to be at least one group that tracks and shares this information with the community on an ongoing and regular basis. Future groups could explore methods to create parity in insurance coverage between mental health and substance abuse care and physical health care.

- Given the need for a wide array of informal and formal supports and the shift from the provision of formal services through The Guilford Center to community providers, programs other than through the local management entity (LME) will be needed. To increase coordination, it is recommended that local community foundations as well as agencies applying for grants use this report to guide their efforts.
- Finally, a key finding from all the sources is the role of the consumer. First, in order to provide quality, sustained services, consumer input is needed at all levels of planning, implementation, and evaluation. Second, there is a growing body of research highlighting the critical and unique role that consumer support plays. It is the thread that can link inpatient to outpatient, professionals to community support.

## Resources

- Guilford County North Carolina Resource Guide  
<http://www.guilfordgop.org/assets/RESOURCE%20GUIDE.pdf>
- Mental Health Association Database  
[http://www.mhag.org/mental\\_health\\_support\\_services.cfm](http://www.mhag.org/mental_health_support_services.cfm)
- Senior Resources/Pathways and Protocols  
<http://www.senior-resources-guilford.org/pages/pathways2.cfm>
- 2-1-1 United Way  
<http://www.nc211.org/>
- Mental Health Web Sites Serving Guilford County  
<http://www.nchealthinfo.org/resources.cfm?info=0,207,41,0,0>
- Guilford County Homeless Prevention Coalition  
<http://www.hpcgc.org/Get%20Facts/statistics.asp>
- The Guilford Center  
<http://www.guilfordcenter.com/services/default.htm>



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Chapin Hall Center for Children at the University of Chicago

(<http://www.about.chapinhall.org/conferences/conferences.html>)

North Carolina Treatment Outcomes and Performance System (NC-TOPPS;

[www.nctopps.ncdmh.net](http://www.nctopps.ncdmh.net)

UNCG's Center for New North Carolinians (<http://cnnc.uncg.edu>)

UNCG's Center for Youth, Family, and Community Partnerships (<http://uncg.edu/csr>)

UNC Shep Center Report on Psychiatrists Shortage

[http://www.shepscenter.unc.edu/hp/Psychiatrist\\_Brief.pdf](http://www.shepscenter.unc.edu/hp/Psychiatrist_Brief.pdf)

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