



THE NORTH CAROLINA
SYSTEM OF CARE HANDBOOK
For Children, Youth & Families



**“It’s about children, youth and families,
safe in their homes, schools, and communities.”**



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ACKNOWLEDGEMENTS

This handbook is the product of families and agency partners. It was originally developed in 2004 as part of a Federal System of Care grant in North Carolina.

Led by the Family Partner Coordinators at NC Families United, Inc., this third revision continues to build on lessons learned from families, agencies and community partners about how to make System of Care really work to help children/youth and families.

Additionally, NC Families United staff consulted with child/youth and family providers, other family support or advocacy agencies, state agency staff, and Local Management Entities/Managed Care Organizations (LME/MCOs) to revise this handbook to reflect current changes and progress. This handbook describes North Carolina's System of Care³ key aspects of the current mental health service delivery system, and how other child-serving systems are implementing services and supports within System of Care.

NC Families United, Inc. is North Carolina's only Statewide Family-Run organization for parents, families, and caregivers of children with mental, emotional, or behavior health challenges and professionals who share our mission of advocacy, education and support to improve lives and services offered. It is the statewide Federation of Families for Children's Mental Health chapter, (NFFCMH). Family-run organizations like NC Families United have strong values of family-driven, youth-guided, community-based and culturally responsive care. These standards exist within an overall framework of the organization that is mission driven and aligned with the organization values. The Board of Directors is composed of 51% family members who are representative of the community served.

NC Families United believes that most children can and should be served in their homes with proper supports and interventions in place. NC Families United also believes in prevention, early intervention and community-based services for children/youth and families that promote safety, permanence and wellness in the home, school and community. The hope of NC Families United is that parents who use this handbook, find it to be a helpful tool in supporting them as full partners in System of Care and that it assists them in locating a Family Partner in their area.

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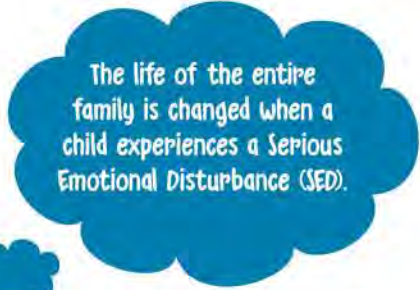
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WELCOME

This handbook is to help North Carolina families with children/youth who experience emotional and/or behavioral health challenges as follows:



The life of the entire family is changed when a child experiences a Serious Emotional Disturbance (SED).

- To learn the services and supports that are available.
- To understand options for accessing care.
- To discover some basics about how the public system works.
- To know when and how to advocate for their children/youth who may need more than what is offered.

In FY2016, the estimated number of children/youth with a severe emotional disturbance in North Carolina under the age of 18 was 233,648.¹ These children are at substantially greater risk for school dropout, school expulsion, drug or alcohol abuse, unplanned teen pregnancy, and conviction of crimes. When a child experiences a serious emotional disturbance, the life of the entire family is changed. Our current systems are often ill-equipped to deal with the multiple and varied challenges presented. Feelings of isolation, frustration and anger become the norm as families attempt to find help for their children and support for themselves.

The NC public behavioral system reached 16.7% of those in need.² Although there still remains a considerable amount of unmet needs, it has taken a remarkable partnership of families, advocates, service providers, policy administrators, and legislators nearly 40 years to establish a system that currently reaches over 17,000³ children/youth with severe emotional disturbance. (See Appendix A for The Evolution of North Carolina's Public Behavioral Health System.) The bedrock of this evolving system has been a national concept and an organizational framework called System of Care (SOC). SOC is the core mechanism for planning, developing and delivering services for all the public child-serving systems in North Carolina. SOC is discussed in more detail in the next section.

¹ Estimate used in FY 2018/2019 State Behavioral Health Assessment and Plan generated 8/31/2017 as part of the SAMHSA Mental Health Block Grant application.

² “ “

³ “ “

NC Families United supports the SOC approach and has pressed the public system to adhere closely to its principles and values. NC Families United has partnered with public systems in increasing the service array and access to those services. However, there is always more that can be done.

NC Families United believes that one way to help families get the help they need as soon as they need it is to provide information so that families know where, who and how to ask for help. This handbook will focus on how to access help in the current public service delivery structure (where the majority of resources for children/youth with behavioral and emotional needs are found) and will preview some of the changes that will affect all the child-serving systems in NC. Even though the handbook's perspective is on the public-funded service delivery system, NC Families United seeks to address questions/concerns that families with Medicaid or private insurance may have.

NC Families United understands that ideally families should be able to access behavioral health services through private agencies, public agencies, hospitals, and primary care doctors. There should be no "wrong door" to access the necessary behavioral supports. Effective public health approaches recognize that illness, health and well-being are influenced by a broad range of social, cultural, economic, psychological, and environmental factors at every stage of life. Because of this, they use a combination of different interventions delivered by a range of partners in different settings. NC Families United is actively reaching out to all the public child-serving systems to create portals to critical behavioral health services and supports.

SYSTEM OF CARE

What is System of Care (SOC)?

The concept of a System of Care for children was coined in 1969, but was formally defined in 1986 as follows⁴:

A system of care is a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with severe emotional disturbances and their families.

This concept/philosophy grew out of the Child and Adolescent Service System Program (CASSP), a federal initiative established by the National Institute of Mental Health (NIMH) to systematically address children's mental health. CASSP became SAMHSA-Substance Abuse and Mental Health Services Administration. SAMHSA is the agency within the US Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation and to reduce the impact of substance abuse and mental illness on America's communities. This federal program invested over \$1 billion dollars in shaping local SOC development in hundreds of communities around the country. This work has culminated in over 30 years of evidence that showed positive outcomes for children/youth and families.

In response to a 1979 Willie M. class action lawsuit, North Carolina became one the first states to pioneer SOC concepts. The suit was on behalf of NC youth under 18 who suffered severe emotional disturbances or at risk of such, whose behavior was characterized as violent or assaultive, and who was either in out-of-home placement or at risk of such and had not been provided appropriate treatment and educational programs. State Mental Health, Juvenile Justice, Social Services and Department of Public Instruction directors or administrators were the plaintiffs. The settlement led these child-serving systems to work together to develop a range of services and supports to meet the needs of the Willie M. class action lawsuit. North Carolina created individualized, "wraparound" plans of care for youth.

⁴A System of Care for Children & Youth with Severe Emotional Disturbances Beth A. Stroul, M.Ed. and Robert M. Friedman, Ph.D. CASSP Technical Assistance Center, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center Funded by the Child, Adolescent and Family Branch, Center for Mental Health Services Substance Abuse and Mental Health Services Administration.

Additionally, North Carolina won three SAMHSA SOC grants between 1994 and 2001. Through these grants, 26 pilot SOC sites were established. NC Families United was also established during the same time period. When the lawsuit ended in 1999, the Willie M. program and the funding that supported it were converted into the Comprehensive Services Treatment Program (CTSP) under the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS). CTSP was designed to serve a broader eligibility group of cross-system children and youth with serious emotional and behavioral needs. Through the implementation of the CTSP, DMH/DD/SAS was able to take the SOC concept statewide by requiring that all counties who planned to access CTSP funding adopt core SOC principles and the organizational framework of child and family teams and local community collaboratives.

System of Care is a way for children/youth and families to develop and implement a plan of care with public and private organizations and others with an interest in the family's success to achieve improved outcomes. In order to work, there has to be an infrastructure of protocols, procedures, and policies at both the local and state levels that require agencies and systems to work in partnership with families.

Core values of the SOC approach include:⁵

- Family-Driven, Youth-Guided Services
- Interagency Collaboration
- Individualized Strength-based Approach
- Cultural and Linguistic Competence
- Evidence-based or informed care practices offered at home or in the child/youth's community

For effective SOC operation, the following must be in place:

- Child and Family Teams at the Individual Level
- Service System Supervision and Management at the Practice Level
- Local Community Collaboratives at the Community Level
- Communication, Resource Sharing and Systems Coordination at the State Level

⁵ See Appendix B for the formal service definition and complete listing of values and principles of SOC as established nationally.



The Child and Family Team is the heart of System of Care.

How does a System of Care work?

In SOC, every effort is made to build on the personal strengths of each child and family, and community. Resources available to children/youth and families through their extended family, neighborhoods and the broader community are recognized as important and enduring sources of family support. It is important to establish an array of more formalized services to help children and families receive assistance when and where they need it most. SOC is clearly based on a strong set of values and principles. SOC is not 'just' a philosophy. SOC is a well-defined model that supports children, youth, families, providers and community partners in working together to empower families in helping their children succeed in home, school, and in their community. This is done through a team approach:

1) Child and Family Teams (CFT), on both the individual and practice levels, is where the rubber meets the road and SOC is actively implemented to promote positive outcomes for youth and families. **CFT's** provide direct services and supports for children/youth with emotional and behavioral challenges and needs, and their families, who often need a flexible mixture of formal agency services and informal supports (such as recreational clubs, mentoring by a family friend, faith-based community, etc.) in order to reach their goals. Families may also need support in other life domains like housing, financing, health, education, legal, etc.

Child and Family Teams are the way that children and their families get the help they need to plan/coordinate their services (supported by many of the child-serving systems), have them delivered in a family-driven way, and to constantly assess what's working and what's not working. During the CFT meeting, there is an opportunity to change the plan if it's not working to better meet the needs of the child/youth and family over time. The CFT is the 'heart' of SOC, building a team unique for each family, comprised of those persons who are important in their everyday lives.

2) Community Collaboratives: Community Collaboratives focus on ensuring better outcomes for children/youth with behavioral health challenges and their families. Family and youth representatives along with staff from child-serving agencies across a community come together to develop a coordinated network that:


- **Put the family in the center of care for their children**
- **Is culturally and linguistically responsive**
- **Offers timely access to effective and individualized services and supports**

As stated earlier, in 2001 when North Carolina took SOC statewide, the Division of MH/DD/SAS required that every county adopt SOC principles and the organizational frameworks of CFTs and community collaboratives. In 2006, the NC General Assembly appropriated recurring funds for 30 full-time SOC Coordinators across the state. By July 2012 when North Carolina became a managed care behavioral health state under a 1915 (b)/(c) Medicaid waiver, there were collaboratives in two-thirds of NC counties. The chief management structure of the new system was the Local Management Entities/Managed Care Organizations⁶. Through its contract for state-funded services with the LME/MCOs, DMH/DD/SAS has continued to require that the LME/MCOs be responsible for convening community collaboratives within their catchment areas. As of today, there are seven LME/MCOs in the state and 73 community collaboratives.

Community Collaboratives must be clear on their focus and priorities and use local data to drive and monitor progress on those priorities. Community Collaboratives help create a community where children/youth with behavioral health challenges are identified early and supported in accessing effective, community-based, trauma-informed, coordinated, and family-driven services. Community collaboratives should provide support, information, training, voice and choice to families that will help them make decisions and plans for their care and improve the system for all families.

Families are involved at all levels of SOC as full partners with child-serving agencies, schools, provider agencies, and other in the community. This helps to inform collaboratives about what services and supports are needed in their community in order to help children/youth and families succeed.

⁶ LME/MCOs are quasi-government agencies that are responsible for managing, coordinating, facilitating and monitoring the provision of mental health, developmental disabilities and substance abuse services in the catchment area served. LME/MCO responsibilities include insuring consumers have 24/7/365 access to services, developing and overseeing the provider network, and handling consumer complaints and grievances.



A family driven youth-guided approach eliminates the "one size fits all" mindset when providing services to families.

3) The North Carolina Collaborative is a cross system collaborative and includes a forum for the discussion of issues regarding how agencies, youth and families can work together to produce better outcomes for families. It is a place where decision makers come to work collaboratively to better meet the needs of children/youth and families. The NC State Collaborative is a cross systems collaborative and includes representatives from state/local agencies, public/private providers, administrators, educators, youth, family members and advocacy organizations. These representatives come together in a neutral environment to support the development of recommendations regarding the coordination of services, funding, training and local reporting requirements in an effort to eliminate duplication and make the system more family friendly. By working collaboratively, this group can help identify strengths, issues, barriers and identify policy and legislative mandates that need to be addressed in order to develop a seamless system of care for children/youth and families in North Carolina.

The NC Collaborative supports local Community Collaboratives and ultimately Child and Family Teams by developing relationships among its members, collaborating on child and family focused initiatives and sharing information throughout the State.

How Does this Approach Differ?

An important way that SOC is different from conventional human services delivery is at its core is a Family Driven/Youth Guided approach. This core principle changes the fundamental relationship between the agency systems partners and families. This approach serves the whole family, respects the family's strengths, builds on the family's own knowledge about their children, and does not restrict children/youth or families to a "one size fits all" mindset.

Families are at the center of SOC. Their strengths, concerns, dreams and goals drive the process of service implementation. Families are engaged at the individual level working shoulder-to-shoulder with all collaborative stakeholders to identify and resolve system barriers. They help educate administrators, policy makers and legislators on the importance of partnering with all child serving agencies to maximize existing resources. Families stimulate conversations that support creative new ways to provide the right services in their communities. (See the full definition of Family Driven, Youth Guided in [Appendices C and D](#).)


What are the Outcomes?

When SOC is operationalized in a way that is true to the core principles, the results for families, the communities, and the whole child-serving delivery system can be beneficial and positive in multiple ways. The following are some of the key outcomes that any community can expect from a well-implemented local SOC:

- Increase in school attendance and children finishing school
- Safer schools for children
- Decrease in home, school, and community violence
- Decrease in out of home placement
- Decrease in abuse and neglect
- Decrease in juvenile arrests
- Creation of a child and family friendly System of Care
- Increased power of advocacy for children/youth and family issues in the policymaking system at the state and local level
- Stronger children, youth, families and communities

ACCESSING BEHAVIORAL HEALTH CARE

What happens if a behavioral or emotional health concern is identified for my child?



Behavioral health challenges can change the way a person thinks, feels and acts.

Every family wants to raise children who are emotionally and behaviorally healthy.

According to the North Carolina Child Treatment Program:

“Behavioral/emotional health is gauged by the day-to-day behaviors and emotions of a child. These will change over time, during different developmental stages, or as a direct result of external changes in a child’s life. In general, we want our children to have stable, wide-ranging, and age-appropriate behaviors and emotions. More importantly, caregivers need to know how to react appropriately to changes in the behaviors and emotions of their child.” https://ncchildtreatmentprogram.org/caregiver_kids.php

For children/youth and adults alike, behavioral health⁷ challenges are real and painful. Behavioral health challenges can change the way any person thinks, feels and acts. Children/youth with behavioral health challenges may have serious school problems, have low self-esteem, be fearful, nervous, or use poor judgment. Behavioral health disorders can lead to other challenges such as fighting, drug use, loneliness, and suicide.

If a parent starts to notice changes in their child’s behaviors, temperament, social engagement styles, etc. or if other people who have significant interaction with the child bring concerns to the parent’s attention, this is a good time to seek professional help (via pediatrician/medical staff, child care agencies, community-based child service providers, public agency children’s staff, social workers, psychologists, etc.). A conversation and observation by a professional can often give parents/caregivers important feedback as to whether an intervention is warranted.

⁷ In this handbook, NC Families United uses “behavioral health”, as does SAMHSA as a “general term that encompasses the promotion of emotional health; the prevention of mental illnesses and substance use disorders; and treatments and services for mental and/or substance use disorders.” Glossary of Terms and Acronyms for SAMHSA Grants. <https://www.samhsa.gov/grants/grants-glossary#B>

Once the parent/caregiver determines that a closer look is necessary, they are often advised to have their child/youth assessed or evaluated. Families will often talk to people they know for advice about where to go.

Although NC public child-serving systems share SOC as a common practice, local and state policies and administrative procedures have not followed suit. This has created cross-system barriers. NC Families United's hope is that new system reforms⁸ will include a focus on aligning policies and resources to increase access to behavioral health services and supports in the schools, in juvenile justice centers, child welfare residences, public health settings and a whole variety of community-based settings.

Families can select their agencies and/or change agencies to get the support in addressing their family's particular strengths and needs. Families can identify potential providers a number of ways: brochures, medical doctors/pediatricians, co-workers, family, friends, employee assistance programs, local school district, Social Services, web sites, other child serving agencies, hospitals, advocacy organizations, and other families who are receiving or have received services.

For those who have no idea where to start, an important consideration is whether they have Medicaid, private insurance, or no insurance. Those with private insurance can start by calling their company's information and referral system. Families with Medicaid or no insurance can turn to the Local Management Entity/Managed Care Organization (LME/MCOs) which serves the county where they live. LME/MCOs are the gatekeepers for the local public behavioral health systems in North Carolina. LME/MCOs have Access/24-hour crisis lines that families can call. (See Appendices E and F for copy of the map that identifies the seven LME/MCO regions and for a county listing of the Access/Crisis Lines). During this call, family members describe their concerns, share some demographic information and whether or not they have private insurance. This call is considered a screening.

Sometimes an LME/MCO may be able to offer the services of a Family Partner/Family Navigator or Family Support Specialist, etc. Such a person (who may or may not be someone with "lived experience" as a caregiver of a child/youth with emotional or behavioral health needs and has used the system to access supports for their families) can help families better understand their options.

⁸ See a limited discussion of these opportunities in Section Entitled SOC's Growth in Other Child-Serving Systems pgs. 62-67



Family Partners can provide resources and support to youth and families.

The parent/caregiver should be sure to ask if the LME/MCO has such a resource or if they know how to link to such a resource.

Parents and caregivers are also encouraged to contact NC Families United (www.ncfamiliesunited.org) to locate support in their area. A NC Families United Family Partner Coordinator/Navigator will be able to send families an information packet and depending on the family's location may even be able to offer face-to-face help with next steps.

How does the SOC Process Begin if my Child/Youth is Determined to Have a Behavioral Health Need?

After the initial screening, based on the caller's concerns, their funding eligibility and where the caller lives, the LME/MCO will match the parent/caregiver with a behavioral health agency or "provider agency" who can conduct a comprehensive clinical assessment (CCA) for the child/youth.

Each LME/MCO is required by both *DMA and *DMH/DD/SAS to contract with providers who can provide a range of services and supports. This group of providers is called the LME/MCO Provider Network. The contracts state that SOC as the way that providers will do business. A provider must go through a credentialing and contracting process before they can become a part of an LME/MCO network. This is done to ensure service quality. By setting certain network requirements, the State ensures that families have a choice in who provides their services.

What Should Families Expect from the Provider Agency?

Upon arriving at the providers door or if the provider comes to the family's home, families can expect to go through an "intake" process. This process will begin with sharing information. Families will be asked questions about their child/youth and family, as well as insurance and income questions. The staff will describe behavioral health services and answer questions. They will also be given information about their rights under the law.

*DMA-Division of Medical Assistance

*DMH/DD/SAS Division of Mental Health/Developmental Disabilities/Substance Abuse Services

Families will be asked to sign release of information forms to give permission for mental/behavioral health service providers to treat their child and to exchange information with other agencies (as necessary to link the family to additional services). Families will also be given information about the cost of services.

After the intake appointment, the Comprehensive Clinical Assessment (CCA) may begin or be scheduled for another day. The CCA will help the family identify the areas of concern to be addressed and make recommendations that could lead the family to a specific service or support needed. The assessment could also lead to the identification of preventive parenting resources or to a formal diagnosis of a mental/behavioral health concern that can be addressed through a particular service intervention and/or medication. A timely and accurate assessment can make all the difference in meeting the child/youth and family's needs quickly and appropriately.

Some things that families should expect to be asked by providers are:⁹

- What do you like most about your children/youth (looking for parent preferences and differences)?
- What are your child's strengths – what does your child do best; what is your child interested in?
- What are your goals– what would life look like if you received the needed supports?
- What are your dreams for your children and family?
- What do you see as your biggest accomplishment and your family's biggest accomplishments?
- What makes you and your children happy?
- What are your favorite memories of your family?
- What special rules do you have in your family?
- Who are your friends and your children's friends, who do you call when you need help or want to talk, and who do you consider to be a support?
- How does your family have fun and what do you prefer to do?
- What are your family's traditions or the cultural events you participate in, and how do you like to do this?
- What are the special values or beliefs that you learned from your parents or others?
- What are your connections to the faith community or if and how you worship?

⁹ Family Support America (1997) Making Room at the Table

After the CCA is completed, even if the provider says that they can provide the services recommended through the CCA process, families still have a choice of providers to work with to plan, deliver and monitor services that build on strengths and meet their particular needs. Families should expect to be fully informed about the services recommended by that provider and should feel free to ask what other providers in the LME/MCO network can offer the same services. (See Appendix G for “Tips on Choosing A Provider”). Families should ask questions about the way services are delivered and express preferences that are consistent with their family’s culture. If the family decides that they would like a different provider or if additional providers are recommended for certain services, this provider should offer assistance in locating agencies that support families’ unique strengths and needs.

This is another point in the process, when a family can ask if there are any local family partner or support organizations that they can be linked to for additional information.

The way the services unfold in SOC is different for each family because they are built on the unique strengths and needs of each family. The goal is to make sure children/youth with behavioral, emotional, education and/or safety concerns and their families get the specific services and supports they want and need. The individuals providing specific services and/or supports to the family, should also be encouraged to participate on the Child and Family Team.

“Professionals” a Family May Encounter?

Behavioral health professionals such as social workers, case managers, therapists, counselors, psychologists, and psychiatrists can help identify special behavioral health challenges and needs to assist in determining the best treatment. Many of the individuals who do the assessment/evaluations will be licensed clinicians, while those who link families to services and other resources do not necessarily have to be licensed. These professionals should participate as active members of each CFT so that all services and supports are coordinated for the child/youth and family.

Listed below are their specialties:

- **Psychiatrists:** A Medical doctor that specializes in the diagnosis and treatment of mental illness and can evaluate patients to determine whether their symptoms are the result of a physical illness, a combination of physical and mental ailments or strictly psychiatric. They can prescribe medication.
- **Psychologist:** A Specialist in Psychology which is a science that deals with thoughts, emotions and behaviors. They can provide testing, evaluation, assessments, psychological theory, research methods, psychotherapeutic techniques and is usually responsible for developing behavior plans.
- **Social workers:** A licensed clinical social worker with a master's degree in social work can provide assessments, diagnosis, counseling and a range of other services. They cannot prescribe medication. They can assist individuals, families and communities in overcoming a variety of social and health problems.
- **Psychiatric Nurse:** A Registered Nurse (RN) with extra training in mental health. They work with individuals, families or communities to evaluate mental health needs, assist with medication management and assist other mental health professionals in treatment and referral.
- **Physician Assistant:** A Certified Physician assistant practices medicine as a primary care provider or in collaboration with a physician. They can diagnose, treat mental health disorders, counsel on diagnosis, treatments, and prognosis. They can also provide education and medication.

(Source: Adapted from **Mental Health Providers: Making the Right Choice: MayoClinic.org**)

Other Behavioral Health Providers:

- **Marriage and Family Therapist:** May be a psychiatrist, psychologist, social worker or nurse.
- **Pastoral Counselor:** A Member of the clergy who integrates religious concepts with training. This professional does not require a license.
- **Paraprofessional:** A trained person whose job is to help a licensed professional. This professional does not require a license.
- **Family Partner Coordinator/Navigator:** The lead Family Partner (most/if not all are Nationally Certified) who is or has been a parent/caregiver of a child ages 0 to 18 who have received services and therefore has firsthand experience within the child and family service system. Because of their lived experience and training, such persons have expertise that other practitioners cannot offer.

- **Peer Support Specialist:** These specialist support individuals with struggles pertaining to mental health, psychological trauma or substance use. Because of their lived experience and training, such persons have expertise that some professionals cannot duplicate.
- **Behavioral Specialist:** The individual responsible for assessing children with behavioral issues, collecting data, working with teachers, counselors, psychologists and parents to create a behavior plan for the youth and evaluating the effectiveness of the plan.

How Families Partner/Work with Professionals/Provider Agencies When Choosing Services and Interventions

Families are the experts of their children/youth and know best what their family needs. Working with providers, public agency staff, and other community resource persons, families should be made to feel comfortable enough to share important knowledge about their child's strengths, interests and needs. Families should also feel encouraged to ask questions about services and interventions.

Some approaches to consider:

- Ask for all available information about a suggested service or intervention for your child/youth and family.
- Determine if current services are or are not working for your child and family. If not, have a discussion about making changes and only keep what's working well.
- Discuss using a service or intervention with your CFT, with family supports, Family Partner Coordinators/Navigators, and with a trusted provider who knows your child and family. Family-driven involvement is critical to the success of services and interventions for children. Decision about your child's treatment and support services should be made after thorough discussion.
- Use a service or intervention on a trial basis. Plans are built around what families do well and fit with their beliefs. Members of the CFT are committed to a plan that works for the family and they share in the responsibility for successful outcomes. At the end of the trial period, the child/youth's progress will determine the service or intervention's effectiveness and next steps. However, be sure you understand the length of time it usually takes for the service or intervention to be effective. The time frame for effectiveness varies from family to family and child to child. All plans must be individualized to be most effective.

Some specific questions for parents/care-givers to consider asking and discussing with the CFT and professionals providing services:

- **Is this an Evidence-Based Practice? If so, is there a description of the practice and how it works? (Evidence-based meaning treatment has been researched for effectiveness and clinical expertise provided risk and benefits of treatment. However, all treatments do not have to be evidenced-based to be effective).**
- **Is there an evidence-based treatment available for my child's diagnosis?**
- **If you are not recommending an evidence-based treatment, please explain why.**
- **What changes should we expect to see?**
- **How long before you think we will see these changes?**
- **What is my role in treatment?**
- **Are the services recommended directly related to my child's person-centered plan and individualized to support?**
- **Will the recommended services work well with the culture of our family?**

The parent/caregiver and child/youth should always keep in mind that they are part of a team that should be working together to find solutions and develop a plan.

If the family is not comfortable with the individuals working with the family, do not hesitate to bring this to the attention of the agency's supervisor. If after trying to resolve the issue, the family still feels uncomfortable, the family may ask for a change in staff.

If the family is uncomfortable with the provider agency, the family has a right to request a new agency and the current provider should be prepared to facilitate the transition. If there is a concern or a complaint that the family would like to make regarding either specific staff or a provider agency as a whole, the parent or legal guardian can contact the LME/MCO in their county to make a complaint or file a grievance. (**See Appendix E** for the list of LME/MCO offices and their contact numbers). It is important that families take the time to inform the managing entity of problems in their network. It is the LME/MCO's responsibility to review their data and identify agencies with high complaint rates so that they can be removed from the network if there is evidence they are ineffective.

Who Decides the Services my Child will receive?

The NC SOC approach emphasizes a partnership between the family and the agency helping the family to find the best solution for their children. While agency staff will have clinical knowledge and experience to share with the family, they know themselves best and understand what will fit within their family culture and environment.

The CFT plan is driven by the family and supported by the knowledge and experience of the other team members. Within the current NC Managed Care setting, once the CFT is established, the behavioral health provider is responsible for submitting the behavioral health services pieces of the plan to the LME/MCO to be reviewed by clinicians. These clinicians review the child's Comprehensive Clinical Assessment and the proposed service plan to determine whether the child/youth meets medical necessity (i.e. whether his/her behavioral health concerns meet a high enough threshold of need to require the service). These reviews are called utilization management reviews. The purpose of such reviews is to help the LME/MCO determine whether and how much of a particular service resource is necessary to address the level of the child/youth's concern. Once the LME/MCO clinician determines that the child does meet medical necessity, the clinician authorizes a service plan that will allow the child/youth access to a specific number of units or billable hours of the desired or needed service.

If the utilization review process determines that the child/youth does not meet medical necessity, the parent/caregiver working with the provider will have appeal rights. Sometimes, a need for service or treatment for children may exceed a policy limit or may not be covered by policies within the state Medicaid Plan. When this happens, your request will be considered for coverage under the broader limits of the Federal EPSDT (Early and Periodic, Screening, Diagnostic, Treatment) benefit.

Source: DMH website

<https://dma.ncdhhs.gov/providers/programsservices/medical/Health-Check-Early-and-Periodic-Screening-Diagnosis-and-Treatment> 10/10/2017.

(See Appendix H for The Pediatric Medical Necessity Review and ESPDT Guarantee).



BEHAVIORAL HEALTH CARE SERVICES

Communities need access to a range of behavioral health interventions to support healthy children/youth. In 2013 and 2015, the federal government issued informational bulletins that recommended the kinds of services that would allow children and youth with significant emotional, behavioral and mental health needs to live successfully in their own homes and communities.¹⁰

Over the past 20 years, North Carolina has made considerable progress in establishing an array of those recommended services. However, funding limitations, different levels of investment in each community decisions and inconsistent provider capacity across the state, has resulted in unequal access to key services.

Each of the current seven LME/MCOs have contracts with a network of providers intended to provide an array of services and supports for children, youth, and adults. The following outlines the types of services generally found across the state.

Home-and Community-Based Treatment and Support Services

Once behavioral health concerns have been identified for a child/youth, the optimal approach is to meet the specific needs in the home or community setting in order to address quickly and with minimum disruption to the child and family's life. In NC, many of these services are provided through public and private behavioral health agencies. Caregivers can find out what exists in their community by contacting the LME/MCO that serves their county.

What follows are the general components of a comprehensive community-based continuum of behavioral health services which may or may not exist within every NC community.

¹⁰ Joint CMCS and SAMHSA Informational Bulletin May 7, 2013 Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions, Cindy Mann, Director, Center for Medicaid and CHIP Services and Pamela S. Hyde, Administrator, Substance Abuse and Mental Health Services Administration and Joint CMCS and SAMHSA Informational Bulletin January 26, 2015 Coverage of Behavioral Health Services for Youth with Substance Use Disorders, Vikki Wachino, Acting Director, Center for Medicaid and CHIP Services and Pamela S. Hyde, Administrator, Substance Abuse and Mental Health Services Administration.

Screening for Behavioral Health Needs: A short interview is conducted by behavioral health professional with parent or legal guardian of the child/youth to determine whether the identified behaviors or concerns about the child requires attention and could be improved or addressed with a service or support.

Comprehensive Clinical Assessment (CCA): An intensive clinical and functional face-to-face evaluation of the child/youth's presenting mental health, developmental disability, and substance use concerns. This assessment results in a written report that provides the clinical basis for the development of the child/youth's service plan (Medicaid and Health Choice Clinical Coverage Policy No. 8C, pg. 15. Amended date: July 1, 2017)

Outpatient Therapy: Counseling for children/youth and their families to address ordinary or low-level challenges in one of their daily settings or to prevent a particularly difficult emotional event from having a more severe, longer lasting impact on a child/youth. Therapy may be delivered either individually, with a family or with a group of children/youth with similar issues. Therapists may be social workers, counselors, psychologists or a variety of licensed clinicians. Therapy can be offered in office-based settings, in the home, and/or in other community settings such as schools. When seeking services for children/youth with substance use challenges or suffering both mental health and substance use challenges, it is important for parents/caregivers to explore the outpatient provider's experience and skill level in working with substance use disorders.

Cognitive Behavioral Therapy: A common form of psychotherapy available in NC that emphasizes the way we think can impact our feelings and our actions.

Trauma and/or events that disrupt the child's relationship with his or her parent/caregiver are the major factors that can interfere with a child's healthy emotional growth. (See more discussion on this at (https://ncchildtreatmentprogram.org/caregiver_kids.php).

There are specialized therapies that have been developed to address such factors. The following therapies have a specialized approach usually supported by an authorized manual, delivered by trained clinicians with specific credentials, and evidence that the approach has been tested and shown to be effective with certain individuals demonstrating specific symptoms. These specialized therapies are called evidence-based treatment models. In NC, families can find therapists trained in these specific evidence-based treatment models:

- Dialectical Behavioral Therapy (DBT)
- Multi-Systemic Therapy (MST)
- Family Centered Treatment (FCT)
- Applied Behavior Analysis (ABA)
- Attachment and Biobehavioral Catch-up (ABC)
- Child-Parent Psychotherapy (CPP)
- Parent-Child Interaction Therapy (PCIT)
- Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Eye Movement Desensitization and Reprocessing (EMDR)

See Appendix I for more information about these treatment models and a website to locate therapists who have received North Carolina-approved training in these areas.

There are also other evidence-based therapies such as Functional Family Therapy, Motivational Enhancement Therapy, and promising practices such as Seeking Safety and Equine Assisted Psychotherapy. Check with your local LME/MCO for a complete list of evidenced-based and promising practice treatment models.

Medication Management: Service where a psychiatrist or trained medical professional interviews periodically the parent/caregiver and child/youth taking a prescribed psychotropic medication to see if the symptoms for which the medication was originally prescribed are being addressed and whether there should be adjustments in the medication being prescribed. Particularly in rural areas where the number of psychiatrists are few and the distance great, some LME/MCOs are contracting with providers to use telemedicine to provide access to families for medication management.

Before medication is prescribed there should be a formal evaluation where a psychiatrist or a pediatrician (trained in children psychotropic medications) gives a lengthy interview to identify the child's emotional or behavioral issues and the child/youth's biological make-up to determine if there is an appropriate medication for the issue and what the appropriate dosage should be given the child's age and weight.

Family and Youth Peer Support: Service that matches youth and their families with trained youth or family members with "lived experience" (i.e. who have personally faced the challenges of coping with serious mental/behavioral health conditions, either as a consumer or a caregiver). Peers provide support, education, skills training, and advocacy in ways that are both accessible and acceptable to families and youth. The support includes assisting families in developing and linking with formal and informal supports; instilling confidence; assisting in the development of goals; serving as an advocate, mentor, or facilitator for resolution of concerns; and teaching skills necessary to improve coping abilities. (SAMHSA 2013 bulletin)

Intensive In-Home Services: Therapeutic interventions delivered to the child/youth and family in their homes or other community settings to improve child/youth and family functioning and prevent out-of-home placement in hospital or psychiatric residential treatment settings. The services are typically developed by a team that can offer a combination of therapy from a licensed clinician and skills training/support from a paraprofessional. The components of intensive in-home services include individual and family therapy, skills training and behavioral interventions. Typically, staff providing intensive in-home services have small caseloads to allow them to work with the child/youth and family intensively, gradually transitioning them to other formal and informal services or supports, as indicated. (SAMHSA 2013 bulletin)

Multi-systemic Therapy: An intensive (scientifically proven) family and community-based treatment program/intervention that focus on addressing all environmental systems that impact chronic and violent juvenile offenders -their homes, families, schools, teachers, neighborhoods and friends. MST therapist are usually on call 24/7 to provide tools to caregivers to support the reduction in criminal and undesirable behaviors.

Crisis Services: Services are available 24 hours a day, 7 days a week, to help during a mental health emergency. In NC such supports include mobile crisis outreach services, hospital emergency departments, facility-based crisis services and behavioral health urgent cares. At this point, in many communities, families have had to rely primarily on hospital emergency departments for such services, but in recent years there has been a concerted effort to develop child/youth facility-based crisis centers, emergency therapeutic foster care homes (Rapid Response Homes), behavioral health urgent cares (open part of the day) and support for the development of mobile crisis units designed to meet the emergency needs of children/youth in psychiatric crisis at home or in community settings such as schools. The goal is to provide emergency support that stabilize children/youth quickly and enable them to return to their homes as soon as possible, thereby minimizing the trauma of the event.

Respite Care: Service that provides a break for parents/caregivers who have a child with serious emotional or behavioral challenges who may require constant supervision and support. Trained parents or practitioners take care of the child for a brief period of time to give families relief from the strain of caring for the child. This type of care can be provided in the home or in another location.

Day Treatment: Service that is offered at minimum 4 hours a day, five days a week for children/youth whose emotional or behavioral challenges limit their ability to learn effectively in a traditional education setting. The program could be offered in a separate facility or within a school setting. Ideally the program includes a blend of special education, counseling, parent training, vocational training, skill building, crisis intervention, and recreational therapy.

Partial Hospitalization: A program usually furnished by a hospital as a distinct and organized intensive treatment service of less than 24-hours daily care. It is not a substitute for inpatient care, however, for some patients, the availability of partial hospitalization may shorten the length of stay of a full hospitalization or serve as a transition from inpatient to outpatient care. It may allow some patients to avoid hospitalization. Placement in a partial hospital program is a clinical decision that can be made only by a physician thoroughly knowledgeable about the patient's illness, history, environment, and support system.

Independent Living: Service that teaches youth how to handle financial, medical, housing, transportation, and other daily living needs, as well as how to get along with others. Some programs might focus on getting and maintaining job skills. These services are offered in a variety of public and private community-based settings within communities and often are paired together with other programs to enable youth the ability to gain an array of skills. Less frequently available are residential settings where youth have opportunities to develop comprehensive independent living skills.

Substance Use Intensive Outpatient Treatment: Service designed to address youth's substance use levels moving beyond experimentation levels. Outpatient behavioral treatment includes programs that typically offer forms of behavioral therapy such as:

- Cognitive-behavioral therapy, which helps individuals recognize, avoid, and cope with the situations in which they are most likely to use substances like drugs or alcohol.
- Multidimensional family therapy - developed for adolescents with substance abuse problems as well as their families, which addresses a range of influences on their substance abuse patterns and is designed to improve overall family functioning.
- Motivational interviewing, which makes the most of people's readiness to change their behavior and enter treatment.
- Motivational incentives (contingency management), which uses positive reinforcement to encourage abstinence from substances.

Source: [www.drugabuse.gov \(treatments\)](http://www.drugabuse.gov/treatments)

Source: www.samsha.gov

Out-of-Home Treatment Services

There are times when children/youth's emotional or behavioral struggles may be so severe that they cannot be managed safely within the family's home. The child/youth's need may require a higher level of clinician intervention and supervision for a limited time until the child/youth is able to stabilize and function more rationally. This level of service need might result in a child/youth having to be placed in an out-of-home service that may even require the child/youth having to leave his or her home community.

Under best practice circumstances these placements should be short-term placements that keep the child/youth connected to his or her home and community as much as possible and all who support the child/youth and his/her family work to get the child/youth back to his/her community resources and home as soon as is possible.

Rapid Response Homes: A therapeutic short-term residential option for children dealing with serious behavioral or emotional disturbances or family crises. Such residential crisis stabilization services are designed to prevent the need for psychiatric inpatient treatment and coordinate a successful return to the family at the earliest possible time. Best practice during these short-term stays encourages regular contact between the provider team and the family to prepare for the child/youth's return to the family. (Alliance Website 10-04-2017/SAMHSA 2013 memo)

Medical Detoxification: A monitored process involving abstinence to clear the drug from the body, accompanied by support during the physical and psychological changes that result. (Alliance Behavioral Healthcare 2017)

Therapeutic Foster Care: Children live in a home with trained therapeutic parents. There are usually no more than 2 or 3 children in the home. The children attend the school in the TFC's neighborhood, when possible. One evidence-based treatment model of therapeutic foster care that can be found in parts of NC is the Multi-Dimensional Treatment Foster Care (MTFC). This model developed from the concept of Parent Management Training. The important components are:

- Increased supervision
- Positive adult-youth relationship
- Increase positive peer relationships
- Family management skills

This model attempts to decrease anti-social behaviors that are openly displayed as well as those that are not so obvious, increase appropriate behavior, and build pro-social skills. It utilizes parents, teachers, and other adults as change agents for the child. Individual and family therapists, as well as a program supervisor, contribute to the child's treatment. Youth must progress through a three-level system of supervision, rules, privileges and rewards.

Therapeutic Group Home Care: Children/youth (approximately 4-6) live in a home run by a provider agency that offers a structured therapeutic environment. Level II homes have staff available 24 hours, but in the evening, staff may sleep. Level III homes must have awake staff available 24 hours. Therapy and social skills training is provided. Children/youth living in therapeutic group homes usually attend school in the group home's community when possible.

Substance Use Residential Treatment: Provides structured, communal living serving as step-down or transition from more restrictive environments and can be very effective, especially for those with more severe problems (including co-occurring disorders). Licensed residential treatment facilities offer 24-hour structured and intensive care, including safe housing and medical attention. Residential treatment facilities may use a variety of therapeutic approaches, and they are generally aimed at helping the patient live a drug-free, crime-free lifestyle after treatment. Examples of residential treatment settings could include:

- Therapeutic communities, which are highly structured programs in which patients remain at a residence, typically for 6 to 12 months. The entire community, including treatment staff and those in recovery, act as key agents of change, influencing the patient's attitudes, understanding, and behaviors associated with drug use.
- Shorter-term residential treatment, which typically focuses on detoxification as well as providing initial intensive counseling and preparation for treatment in a community-based setting.
- Recovery housing, which provides supervised, short-term housing for patients, often following other types of inpatient or residential treatment. Recovery housing can help people make the transition to an independent life—for example, helping them learn how to manage finances or seek employment, as well as connecting them to support services in the community.

Source: www.drugabuse.gov

Source: www.samhsa.gov

Psychiatric Residential Treatment Facility (PRTF): Facilities that provide treatment 24/7 and are divided in units that serve a maximum of 12 children/youth. These are locked facilities. Children/youth with serious emotional disturbances receive constant supervision and care. Treatment may include individual, group, and family therapy; behavior therapy; special education; recreation therapy, and medical services. Residential treatment averages 6 – 9 months.

Inpatient Hospitalization: Mental health treatment provided in a hospital setting 24 hours a day. Inpatient provides: 1) short-term treatment in cases where a child/youth is in crisis and possibly a danger to self or others, and 2) diagnosis and treatment when the patient cannot be evaluated or treated appropriately in an outpatient setting.

There are times that children/youth may need highly structured, therapeutic environments of group homes, psychiatric residential, and inpatient hospitalization for the short-term, especially if there are medical needs, coupled with emotional/behavioral health issues. NC Families United supports policies and programs that seek to limit these placements and to reduce the lengths of stay even when such placements are found necessary.

Coordination of Services

In addition to a comprehensive service array, families need a process that will assist in ensuring multiple services are delivered in a coordinated and therapeutic manner. This allows children/youth and their families to move through the system of services in accordance with their changing strengths and needs.

Case Management services has been a process in NC for many years. Case management had been a stand-alone service provided by many public mental health providers. Today public behavioral health providers largely provide case management embedded in higher level (enhanced) Medicaid services (such as, Multi-systemic Therapy, Intensive In-Home therapy, or Day Treatment).

Case management (MH/SA TCM) is an activity that assists the family in gaining access to necessary care: medical, behavioral, social, and other services appropriate to their needs. Case management is individualized, person-centered, empowering, comprehensive, strengths-based, and outcome-focused. The functions of case management include:

- a. Case Management Assessment
- b. Person-Centered Planning
- c. Referral and linkage
- d. Monitoring and follow-up

**(Source: NC DMA MH/SA Targeted Case Management (TCM)
Clinical Coverage Policy No: 8-L, Amended Date: October 1, 2015)**

Care Coordination: Care coordination (another form of service coordination) is the deliberate organization of Medicaid children/youth care activities to facilitate appropriate delivery of health care services, connect eligible children/youth to the appropriate level of care, and identify and address eligible child/youth's needs and barriers to treatment engagement. (Source: 2018 – PIHP Contract between NC DHHS Division of Medical Assistance and LME/MCO, pp. 26-27.)

Under the current NC Managed Care System for Behavioral Health (described on page 40, <https://www.ncdhhs.gov/news/press-releases/dhhs-releases-vision-future-behavioral-health>) the care coordination function is handled by the LME/MCO organization. The LME/MCO is required by its contracts with the Department of Health and Human Services to provide Care Coordination for high cost/high risk consumers.

Children/youth with Medicaid who meet the criteria for special healthcare needs will be prioritized for care coordination. Children/youth who have no other payer than public/state non-Medicaid funds, care coordination is prioritized for those being discharged from State facilities, community hospitals, and crisis services. The inpatient stay is paid by the LME/MCO who is responsible for, within available resources, both ensuring continuity of care for individuals in services, and availability of services throughout the year.

LME/MCOs provide the following Care Coordination functions:

- a.** Identification of clinical needs
- b.** Determination of level of care through case review
- c.** Enrollee contacts
- d.** Arranging for assessments
- e.** Clinical discussions with Enrollee's treatment providers
- f.** Assistance with development and monitoring of Enrollee treatment plans, including but not limited to Person-Centered Plans and Individual Service Plans

Administrative care coordination functions include, but are not limited to:

- a.** Addressing additional support services and resources
- b.** Assisting Enrollees with obtaining referrals and arranging appointments
- c.** Educating Enrollees about other available supports as recommended by clinical care coordinators
- d.** Monitoring Enrollee attendance in treatment

In addition, to the service coordination mechanisms described above, NC DMH/DD/SAS is partnering with NC Families United to implement a national evidence-informed/based supportive service – High Fidelity Wraparound (HFW) in several sites through a Federal SAMHSA grant, and a Governor's MH/SU taskforce pilot program. HFW intensifies the service coordination for a family by providing a team that includes a Coach/Supervisor, Facilitator, a Family Partner and/or a Youth Peer Support. This intensive service is specifically for children/youth who are transitioning from PRTFs or residential placements. This service is intended for those children with severe emotional or behavioral challenges with multi-system involvement and complex family relationships. These pilots are demonstrating the value of HFW team-approach to serve the enrolled youth/family/caregiver for 12 months on average.

If the family agrees to participate, the Wraparound Team from the provider agency will:

- Connect with the youth and family to build rapport.
- Conduct strengths and needs assessment with youth, family and supports.
- Participate in the Child and Family Team held at the PRTF/Out-of-Home Placement and bring community resources to the discharge planning process.
- Start developing the Child and Family Team who will support the family when the youth has returned to the home and community.
- Work with the family to increase natural supports in the transition to the community.
- Begin collecting outcome data from the youth to evaluate the pilot.

4 Phases of NC High Fidelity Wraparound include:

- Engagement and Team Preparation
- Planning
- Implementation
- Transition

High Fidelity Wraparound teams strongly encourages and advocates for collaboration between themselves and all service providers involved with the youth and family. The HFW team will initiate and work to maintain communication between all involved to ensure strong coordination of services, support of the youth and family, and progression toward positive outcomes. Examples of this coordination and collaboration would be the co-facilitation of Child and Family Meetings and the development of combined agendas. This allows for the family to reduce the number of meetings they need to attend and ensures all involved parties have the same information regarding treatment goals, progress, and any barriers to address.

It is recommended for the High Fidelity Wraparound team to work with the PRTF, the family, and the youth/child at least 2 weeks but up to 30 days prior to discharge to establish and maintain engagement, smooth transition, and to encourage successful outcomes.

Anticipating positive outcomes, DMH/DD/SAS and NC Families United are working with several LME/MCOs to develop a sustainability plan for this service and hope to offer this service statewide within the next two years as NC moves into Integrated Health and Behavioral Health Managed Care.

Trauma-Informed System

Another critical aspect of the behavioral health service delivery in NC is the degree to which the system has become a trauma-informed system. DMH/DD/SAS has invested in the increased number of licensed clinicians who are certified to provide several evidence-based trauma treatment therapies described previously (i.e. currently there are 809 active rostered clinicians across the state)¹¹.


Through a Federal SAMHSA grant, the State Division of Social Services has done considerable work in developing a trauma assessment protocol for foster care children in a number of local counties. A few LME/MCOs are providing trauma-informed and resiliency-building trainings for community partnerships throughout their catchment area. Several school systems are also providing trauma-informed training for their school personnel. However, the NC SOC has a way to go before the public child-serving systems have created comprehensive trauma-informed system that quickly and accurately identifies child/ caregiver trauma, responds appropriately throughout the family's movement through the service delivery systems, and can provide evidence-based, trauma-informed treatment as needed.

NC Families United is working with a cross-system state workgroup to develop and implement a workplan to shift all the systems in that direction over the next two years. (See Appendix J for more information about developing a Trauma Informed System).

How can I find out more about services in my community?

There are many services available in NC SOC. Some services are provided through behavioral health clinics or independent practitioners. Other local agencies are Departments of Social Services, Department of Public Health, Department of Public Instruction, Administrative Office of the Courts, Department of Public Safety and Department of Adult Corrections-Juvenile Justice.

¹¹ NC Child Treatment Program report



Ask for all information about services and interventions; get help in determining what is best for your family.

Some services are informal supports through clubs, churches, recreation centers, friends, and family members. In SOC, all of these services and resources become integrated for a child and family through a unified Family-driven Child and Family Team. Parents/care-givers can learn more about resources for their child/youth in their community by:

- Asking a Family Partner Coordinator/Navigator or Child and Family Team Facilitator
- Getting involved in the local SOC Community Collaborative
- Getting referrals from professionals
- Calling the Local Management Entity (LME)/Managed Care Organization (MCO)
- Contacting the local System of Care Coordinator ([see Appendix F](#))
- Talking with the Child and Family Team about what the family wants and what the family thinks their child needs
- Contacting your local or State Parent Organization – North Carolina Families United can also put you in contact with a local Family Partner/Coordinator/Navigator



CHILD AND FAMILY TEAMS

What is a Child and Family Team?

Child and Family Teams are family members and their community supports that come together to create, implement and update a plan with the child/youth and family. The plan builds on the strengths of the child, youth and family that addresses their needs, desires and dreams.

Team members work together with the family to write an individual Child and Family Plan based on what the child/youth and family wants and needs. The child and family team meet and decide on the frequency of meetings.

There are Seven Practice Principles that support the CFT Process:

1. Family, children and youth are full partners.

When families and agencies meet, all share their perspectives.

2. Planning is led by the family.

Agency mandates are acknowledged and the family notes what they most want to focus on.

3. Meetings are a safe, supportive place for all members.

Meetings are held in a neutral place (church, community center, etc.) that feels comfortable for the family.

4. Meetings include people who can help the family succeed.

Participants might include extended family, close friends, and/or neighbors.

5. Plans are built around what families do well and fits with their beliefs.

Families' church may play a role in the plan; the plan for child includes a focus on areas of interest and ability (arts, mechanics, writing, etc.)

6. Members are committed to the plan and share responsibility for successful outcomes.

Family members and agency representatives are held responsible for following through as planned.

7. Plans are changed when they are not working for families.

Regular feedback sessions alert team members to challenges and provides an opportunity to ask family what might work better.



A family partner can articulate lessons learned from his/her own lived experience.

Who is on a Child and Family Team?

The parent/caregiver, legal guardian, youth/child are all part of the CFT and decides who should be at the meeting. Children who are old enough to attend meetings, understand the process, and can make choices, should be a part of their CFTs. The team includes anyone who is important to the family and who knows their strengths and needs. Team members are usually people who are part of the child's education, care, custody, treatment and others who know the family and lend support. They can be:

- Family members
- Friends and neighbors
- Community members
- Members of businesses, churches, or other groups
- Teachers and other school staff
- Facilitator
- Family Partners
- Service providers (doctors, social workers, case managers, court counselors, teachers, school nurses, etc.)
- Others who know your family well

Who is a Family Partner?

A Family Partner is a person who can articulate lessons learned from his/her own lived experience *parenting a child/youth with social/emotional or behavioral challenges and has specialized training to assist and support families raising children/youth who experience social/emotional, developmental, behavioral, substance use, or mental illness concerns. A Family Partner collaborates with child and family serving systems and family and youth organizations to improve family outcomes and strives to eliminate stigma and discrimination.

*Parenting a child is defined as the primary caretaker of a child for an extended period of time who has decision making authority for that child.

NC Families United refers to family support as Family Partners, Family Advocates or Family Navigators doing similar work.

How does the Family Partner help in the CFT?

The family partner supports the SOC values and principles. The values and principles are implemented when addressing families needs and insures fidelity to the CFT process.

Family partners help in promoting collaboration among families, providers, service givers and natural supports. (Natural supports may include the faith based community, neighbors, and community organizations such as the YMCA, Boys & Girls Clubs, etc.)

Family partners assist the family in preparing for a CFT and collaborate in the follow-up with the family after the CFT. They help identify innovative and creative resources in the community to promote activities for families that help fill-in the unmet needs.

Should I ask friends to be on my CFT?

A strong team is one that has a mix of family members, friends, community members, and service providers. As families begin getting more of the support and resources they need through SOC, the need for service agencies decrease. Family members, friends, neighborhood and community supporters should increase which encourages the growth and independence of the family. One of the goals of SOC is to help families become more confident and able to meet the needs of their children without relying only on agency staff.

How many people are on a CFT?

There is no set number of people on a CFT. Each team is different. Most Child and Family Teams have about 6 to 10 people, but teams can be bigger or smaller depending on what each family wants or needs.

Does the team ever change?

Teams do change. New members can be added, and sometimes members leave the team when their help is no longer needed.

What is the role of the Child and Family Team?

The CFT process helps the family create a person-centered plan to identify goals specific to addressing their needs. The CFT can be a safe guard to make sure services and supports are working, resources are available, and suggest changes if the plan is not working or if different services are needed.

What is the role of the CFT Facilitator?

The Child and Family Team Facilitator can help to organize and coordinate the CFT and the planning process. Child welfare uses designated staff who are trained to facilitate CFT's. Mental Health staff who provide enhanced services may volunteer to facilitate initially as well as other team members, with the ultimate goal being the parent/caregiver or youth facilitating their own meeting.

Part of the facilitator's role is to prepare the family for the meeting, set up and lead the CFT. If someone misses a meeting, the CFT Facilitator should try to ensure that person provides relevant information for the plan and later informs the person what happened at the meeting. The CFT Facilitator can provide information so everyone knows about the plan and any changes in the plan. They can also provide follow up to ensure everyone is carrying out their responsibilities. The CFT Facilitator may connect the family with a Family Partner/Navigator. The facilitator is also responsible, along with the family, to keep track of outcomes or results of the Child and Family Plan. In other words, is the Plan working? If not, the CFT Facilitator helps the family and the rest of the team change the Plan.

Who can ask for a CFT meeting?

The family or any team member can ask for a CFT meeting. Because the family knows the child best and spends the most time with the child, it is very likely that the family will ask for a CFT meeting. A CFT meeting must always include the child and family. (A child/youth can be represented in different ways depending on age, location, via phone conference, pictures, etc.). The family can ask for a CFT meeting if there is a crisis or safety concern, a change in their living situation, or another significant life event. Team members who can't attend an emergency meeting are expected to find a way to share their ideas and opinions in time to be addressed at the meeting.

See Appendix K - What Families Say They Want

CHILD AND FAMILY PLANS



Plans are built around what families do well and fits with their beliefs.

What is a Child and Family Plan?

A Child and Family Plan is a written person-centered plan that lets team members and everyone helping the child know what is needed, what is expected, and who will do each part. It lists the people and agencies that will work with the child and family. It explains what people will do and how, where, and when they will help. A Child and Family Plan should always include a detailed Crisis/Safety Plan.

[See more about crisis/safety plans on page 46.](#)

The Child and Family Plan, including the Crisis/Safety Plan, should be very practical and easy to understand.

Who writes the Child and Family Plan?

The Child and Family Plan is written by the Child and Family Team. Team members share information and work together to write an individualized plan (family-driven and youth-guided) for the child and family.

Is the Child and Family Plan related to my child's Individual Education Program (IEP)? What about plans and meetings with other agencies?

One of the core principles of SOC is to coordinate and integrate services. A key goal is to establish one unified Child and Family Team and one unified Child and Family Plan: 1 Family/1 Team/1 Plan.

Individuals with Disabilities Education Act (IDEA) is the Federal Special Education Law that requires IEP's be written for children with disabilities. An IEP is a legally binding document that will stand up in court if the school system fails to provide the services listed on the IEP, such as a point system, time with a resource teacher or testing modification. This law requires that students must receive a Free and Appropriate Public Education (FAPE) that is specifically designed to meet their unique needs and prepares them for further education, employment and independent living.

The public systems that serve children and families have mandates. For example, if the child has a learning disability and has an Individual Education Program (IEP), the school system must complete certain activities and forms to be in compliance with the law. The Child and Family Plan should include all of the services from all agencies that support the child including the strengths, goals and needs which becomes a part of the IEP. This would also apply to a 504 Plan.

A Child and Family Team is intended to work for the benefit of the child and family. Agencies should be expected to make every effort to meet their particular funding or rule requirements within one unified Child and Family Team so that families do not have to attend multiple meetings or have multiple plans for their child and family. NC Families United supports the SOC model of capturing all the information in one unified plan because it is in the best interest of the family.

How is a Child and Family Plan developed?

A Child and Family Plan is written in steps. The steps help everyone think about the family's strengths, the supports and services they need, and who should help the child and family.

What are the steps to develop a Child and Family Plan?

First know the values and guidelines of SOC to support the development of a Child and Family Plan ([See Appendix B](#)).

Next, begin the process:

Step 1

The Family, the Facilitator and the Family Partner work together in choosing team members based on the specific needs of the child/youth and family.

Step 2

The CFT Facilitator sets up a meeting at a time and place that works best for the family.

Step 3

The CFT meet to develop the Child and Family Plan, including a Crisis/Safety Plan. All members sign the plan to show that they agree with and will do what it says. Developing an individualized plan is a process and may take more than one meeting to complete. All members will receive a copy of the plan.

Step 4

Everyone agrees to follow the plan and check in to see what's working and what's not for each goal.

Step 5

The team monitors the plan, reviews the goals, and makes adjustments as needed based on the changes happening within the family.

When is the plan working?

It may take time to see results, but after most services have started, you should begin to see a change. The family and team will know the plan is working when there is progress toward their goals.

What if the plan isn't working?

It may take time for all the services to get started, and then it will take time before you see any changes. If any services are taking too long to get started or are not working, you should tell the CFT Facilitator or your Family Partner that changes need to be made to the plan. The CFT Facilitator or Family Partner should then contact the team to schedule a meeting to update the plan.

What is a Crisis/Safety Plan?

In System of Care, Child and Family Teams help families try to avoid crises and help if a crisis does occur. A Crisis/Safety Plan is an action plan that tells everyone how to avoid a crisis and how to manage an actual crisis situation. See more detail about crisis plans in the Section Crisis Planning & Crisis Supports on page 46.

CHILD AND FAMILY TEAM MEETINGS

What happens at the first meeting?

At the first meeting, you will:

1. Identify goals the family wants to achieve
2. Review the family's strengths, assets and preferences
3. Identify what the families' needs are
4. Develop a plan that will help accomplish the outcomes

What are the steps of a CFT meeting?

Step 1. Meet the team

Everyone will introduce themselves and tell how they are connected to the child and family. Some team members will say how they think they can help and what strengths they bring to the team, while others may know what they can do to help.

Step 2. Talk about the family's strengths

The CFT Facilitator will ask the team beginning with the family to share what the family does well. (functional strengths). This is a chance for all team members to get to know the family better. The CFT Facilitator will review the family's strengths and record them.

Step 3. Talk about the family's goals

The CFT Facilitator will ask what the child and family want to achieve. Goals should be reviewed at each Child and Family Team meeting to determine if they are being met. If these goals are not being achieved, the team should discuss whether the plan needs to be changed.

Step 4. Choose areas (life domains) for the plan

The team will support the family in choosing areas of the child's life they want to plan for first. Usually families choose the two or three areas that are most challenging at the current time.

Some areas (life domains) are:

- Behavior – how the child acts and feels and how they get along with others
- Health – physical well-being or illness (emotional, mental or dental)
- Education – how, what, and where the child is educated or trained for a job and independent living
- Social (friends) – relationships and activities with others
- Living arrangements (residence) – where and with whom the child lives
- Legal – anything related to laws, rights, courts, probation, and custody
- Safety – protection from harm to self or others

Step 5. List and prioritize the child and family's needs

Identify the individualized immediate needs and what should happen in order to reach the goals.

Step 6. List any challenges and who can support the family

Identify who can help address challenges and get the services, supports or resources that are needed. The CFT Facilitator or Family Partner (when available) will help contact any additional individuals who need to be on the team with consent from the family.

Step 7. Develop strategies for each need identified

Strategies are the action steps that say how each need can be addressed so that challenges can be overcome and goals can be met. The best strategies are those that use existing strengths to overcome challenges and meet a need. Everyone on the Child and Family Team will discuss strategies to use. The team will then help choose the best strategies to include in the plan.

Step 8. Develop a Crisis/Safety Plan

The team will develop a plan that identifies what happens when a crisis is showing signs of occurring, including the 'triggers' that have set off crises in the past. It will spell out who will do what to defuse or de-escalate the crisis. The plan informs everyone what to do to help the child and family when the usual strategies are not working. (See Crisis Planning & Crisis Supports on page 46)

Step 9. Make assignments

Each team member including the child and family will have a job to help carry out the Child and Family Plan. Some team members will support the child directly at home, at school, or in the community. Team members can get additional information from others connected to and supporting the family.


Step 10. Set up the next meeting

The last step is to choose a date, place, and time for the next meeting, or to set a schedule for several meetings.



FAMILY & TEAM STRENGTHS

What does 'strengths-based' mean and how is it different?



Families with challenges are not "broken" or "need to be fixed".

Focusing on strengths changes the entire system of services and supports for children and their families. A strength-based philosophy represents a significant shift in the way provider agencies view and work with families. More and more provider agencies are making the shift to a strength-based orientation. The family strength approach encourages agencies and entire service delivery systems to support and reinforce family functioning rather than focusing on individual or family deficits.

Systems that shift from a deficit-based to a strength-based orientation communicate the following attitudes and beliefs:

- All families have strengths. Their strengths are unique and depend on the family's beliefs, cultural background, ethnicity, socioeconomic background, and other factors.
- The absence of particular skills within families or individuals should not be seen as a failure or inadequacy on the part of the family or individual. Sometimes the formal or informal human service system does not promote opportunities for a family to display or learn skills they need.
- Families with challenges are not "broken" or "need to be fixed." A strength-based orientation means that families are approached in ways that focus and build on the positive aspects of functioning.
- Agencies not only accept but highly value individual differences among families and family members.
- The goal of intervention is not "doing for people." The goal is to work with families as partners in order to help them become less dependent on agencies. This means that agencies are not viewed as experts that are expected to solve a family's challenge.

Working with children and families as full partners not only makes good sense but is best practice and supported by research as making a positive difference to achieve better results for children, families, and agencies assisting them. Portland State University gathered the following findings about challenges, needs and results of family partnerships within service planning and delivery teams:

- A.** Comprehensive plans that are developed with genuine family input are more likely to have realistic goals, to include creative and flexible strategies, and to promote a sense of family ownership. When the process is truly family-driven and youth-guided, it is more likely that the plan will meet the individual needs of the families, build on their strengths, and respect their culture.

- B.** The challenge in making this 'best practice' a reality is collaboration between families and agencies as full partners. Some of these strategies can include:
 - Ensuring that family members speak first and last during discussions
 - Making sure families lead the decision-making process and checking in to make sure they are ok
 - Using a Family Partner to support the family's perspective
 - Encouraging families to 'tell their stories' at the team meetingsA family's story can contain important information about hopes, goals, strategies and resources

- C.** If the community is not using some of the strategies described above to help create true family partnerships and to promote family voice and choice, consider getting involved to help them figure out ways to change these practices so that everyone gets better results. Consider talking to your CFT Facilitator, System of Care Coordinator, Family Partner Coordinator/Navigator, the local LME/MCO or the local Community Collaborative about these ideas.

What are "family strengths"?

Family strengths are all the activities, feelings, discussions, and supports that hold a family together and make them strong. Family strengths can be little things like watching TV together, or big things like sharing chores or solving problems together.



Every Family has strength.

Does every family have strengths?

Of course! Every person and every family have strengths. Sometimes we may not see the strengths right away, but they are there. In fact, some of the things we think are “challenges” can have strengths hidden in them.

What are some examples of functional strengths?

Functional family strengths are all the activities, habits, skills, interests, attitudes, and behaviors that make families strong.

Examples of a Child’s Strengths

- Enjoys working with younger children
- Likes to draw, paint, play sports, build or construct things, etc.
- Does well in school, likes math or reading, etc.
- Listens, follows directions and speaking up for themselves or others
- Manages time, tries to solve problems
- Having empathy, being sensitive to others needs

Examples of Family Strengths

- Talks openly about problems
- Has friends and close relatives who can help
- Share chores
- Cook and eat meals together
- Knows how to have fun (games, sports, TV, etc.)
- Laughs and cries together
- Stands up for each other

Examples of Team strengths

- Team strengths are the many ideas, skills, and attitudes they can use to help the family.
- Each member of the team will have different strengths. One may already be helping the child, one may know a lot about school programs, and another may know a lot about community resources.



CRISIS PLANNING & CRISIS SUPPORTS

What if there is a behavioral health crisis?

In System of Care, Child and Family Teams help families avoid crises and if a crisis does occur, the CFT offers assistance. A Child and Family Plan always includes a detailed Crisis/Safety Plan. A good crisis plan will include the following:

- Identification of the child's behavioral symptoms (i.e. warning triggers) prior to an outburst or emotional meltdown
- A list of calming strategies, people or places that help to ground the child in crisis moments
- If safety is an issue, a list of action steps to help the child and family get to safety as soon as possible
- A description of warning signs of a crisis for the child and family
- A first point of contact, then a second and third
- What each team member will do to support the child and family to avoid a crisis
- What each team member will do if a crisis does occur

"Calling 911" is not acceptable as the only strategy for a Crisis/Safety Plan!

The child and family members know best what factors can lead to a crisis and what actions can help defuse it. The best course of action, through careful planning, is to identify cues of an approaching crisis and assign activities that will be carried out to avoid it. This proactive approach is especially important in avoiding unnecessary out-of-home placements and other restrictive interventions. Being proactive could identify triggers that typically set off a crisis, including the child's crisis behavior. This Crisis/Safety Plan indicates who will do what to avoid the development of such a crisis.

At the same time, teams must always be prepared to effectively address an actual crisis situation when all efforts to avoid it have not worked. The Crisis/Safety Plan spells out details about what will happen if/when a crisis does occur such as who to contact, where the child should go, who will take charge and what services will be used to help the child and family. If safety is an issue, a crisis/safety plan always includes strategies for keeping the child, family and others safe.

Without a Crisis/Safety Plan, a child often ends up in out-of-home placement. A Crisis Plan helps everyone react quickly to keep a problem from getting worse; it also makes it possible for life to return to normal as quickly as possible. The Child and Family Team should review the Crisis/Safety Plan at each CFT meeting and make changes as needed or as circumstances change, such as changing schools, changing living arrangements, if a family member becomes unavailable, if there is a change in the family composition, etc.

What if my child has a behavioral health crisis (and I am not already connected to a provider)? Do I have to have Medicaid?

Anyone may request crisis or emergency services in NC for mental health, substance abuse, intellectual and developmental disability issues. One does not need to have Medicaid or private insurance to access these resources:

- If this is a medical or a life-threatening emergency please call 911
- Call the LME/MCO access number for your county. **See Appendix F** for listing of the LME/MCO crisis number by county or go to the DHHS website to find crisis resources in your county
<https://ncdhhs.gov/assistance/mental-health-substance-abuse/crisis-services>
- If you need to contact the police, request a Crisis Intervention Team officer*

***What is a Crisis Intervention Team Officer?**

A Crisis Intervention Team (CIT) officer is one who has received 40 hours or more training to prepare them to assist individuals experiencing a mental health, substance use or developmental disability crisis. The CIT model emphasizes taking individuals to treatment rather than to jail, when it can be accomplished with little risk to public safety.

CIT programs also emphasize that law enforcement and mental health systems work collaboratively to develop a network of services to support people in crisis. More than 7,000 law enforcement officers from more than 350 law enforcement agencies across the state have completed CIT training.

Source: <http://crisissolutionsnc.org/811-2/#more-811>

Three of Many Crisis Supports available to families to consider:

- **Wellness Recovery Action Plan**

The Wellness Recovery Action Plan® or WRAP®, is a self-designed prevention and wellness process that anyone can use to get well, stay well and make their life the way they want it to be. It was developed in 1997 by a group of people who were searching for ways to overcome their own mental health issues and move on to fulfilling their life dreams and goals. It is now used extensively by people in all kinds of circumstances, and by health care and mental health systems all over the world to address all kinds of physical, mental health and life issues.

WRAP has been studied extensively in rigorous research projects and is listed in the National Registry of Evidence-based Programs and Practices.

Source: <http://www.mentalhealthrecovery.com>

- **RPC – A workshop for resource parents**

The Resource Parent Curriculum is a course that provides support and helpful tips and tools for parents who are raising children who are in, or have been in, the child welfare system or institutional care. A child's history can make taking care of them on a day-to-day basis challenging and sometimes stressful. Once a parent understands why a child behaves the way they do, it can be easier to provide support and care to a child who has suffered from trauma. Source: <http://nctsn.org>

- **Mental Health First Aid (MHFA)**

The goals of Youth MHFA is to teach families and members of the public how to recognize the signs and symptoms and how to respond in a mental health emergency until the appropriate help is available. The more knowledgeable people are about mental health disorders, the less stigma will be associated with common life challenges. The more aware people are of the effective supports and treatments that exist, the more young people will get the appropriate help they need. Source:

<https://www.mentalhealthfirstaid.org>



ADVOCACY & COMMUNICATION

What is advocacy?

Advocacy is the process of actively supporting the cause of an individual or group. It consists of helping people get the services they need and giving them support along the way, as well as teaching, coaching, or modeling.

What do advocates or Family Partners do?

Advocates or Family Partners help in many ways. An advocate or Family Partner might help you get ready for meetings, can attend meetings with you, teach you about your rights, gather information, encourage you, or speak out on behalf of you and your family.

Who will advocate for my family?


Many people, including you, can advocate for your family in different ways. In SOC, each family usually chooses one person to be their family advocate. You can choose anyone who you feel will be supportive and helpful to be your advocate. It is a good idea to choose someone who has had experience in SOC, but it is not required.

Why is it important for families to get involved in their local System of Care?

Every community may be a little different in their process of implementing SOC and how they include families. The benefits and opportunities for families should be the same when they become actively involved in the SOC.

Some of the benefits are listed below:

- Provides opportunity to effect meaningful change
- Helps providers to be more accountable to families
- Provides opportunities to network with other families and providers
- Builds knowledge and skills



You are the best
advocate for your family,
use your voice.

- Models community partnerships
- Promotes systems change
- Opens doors to employment
- Increases family-driven voice in policymaking
- Offers leadership role models for other families
- Increases family empowerment
- Decreases the isolation that so many families face when their children are having difficulties

Active family involvement also directly benefits individuals who work with families by:

- Educating agencies on how to partner with families
- Increasing the responsiveness of programs and policies
- Keeping programs relevant and realistic
- Bringing a family-driven perspective with creative solutions and limitless creativity
- Increasing visibility of best practice programs in the community
- Increasing collaboration between agencies and families
- Helping to save money and by reducing unwanted expenses
- Developing a group of supporters who can advocate for programs and agencies
- Increasing Cultural Sensitivity and Responsiveness
- Improving the quality of programs and services

You are an advocate for your child. Every time you do or say anything to improve your child's education or quality of life, you are advocating. When you ask for services or tell someone what your child wants or needs, you are advocating. When you go to school meetings and write plans, you are advocating for your child.

How can I become a better advocate?

KNOW

- Know your rights
- Know the special education laws
- Know your roles
- Know how the System of Care process and principles can support your family

ASK

- Ask questions
- Ask people to explain abbreviations or jargon they use
- Ask for help

TELL

- Tell people about your child's strengths
- Tell people what you want (goals)
- Tell people what your child needs
- Tell people what is working and what is not

How will good communication help my child and family?

If you want to participate fully in the team and be an effective advocate for your child, you must be a good communicator. You have a voice! Good communication helps you tell others your ideas and feelings. Good communication skills allow you to share your story along with your wants and needs.

What if I'm not good at expressing myself?

You don't have to be the world's best speaker to be a good communicator or advocate. What you need are facts and confidence. If you go into meetings knowing your rights and what you want, you will do well. Begin to share based upon where you are. As you learn, grow, and communicate more, your ability to communicate improves and expressing yourself gets easier.

Here are a few tips:

Be prepared

- Go to meetings with a clear idea of what you want to get done
- Think about what you want to say and how you will say it
- Write your thoughts, concerns and ideas down
- Get your records in order
- Talk to someone to find out the meeting agenda
- Bring an advocate, Family Partner or someone who knows you well for support

Use two-way communication

Remember that communication is a two-way street. Be ready to listen and understand the point of view of other team members.

Keep your emotions in check

You will communicate better if you stay calm and stick to the facts. Even when you are angry or upset, always be polite.

Talk about the strengths and concerns.

There may be individuals you don't like or trust, but you should not attack them. Stick to the issues. Talk about things that can be changed.

How can I get my message across to others?

There are three types of communication: passive, aggressive, and assertive. You can be a powerful communicator if you learn how to be assertive.

Passive is too weak.

- You avoid the problems.
- You let others speak for you.
- You agree to everything, even things you don't really like.

Example

“We’ll wait and see how Janice does next year. Maybe she’ll outgrow the challenge. I guess waiting won’t hurt.”

Aggressive Is too strong.

- You don’t care about the rights and feelings of others.
- You attack people, not problems.
- You make demands, not requests.
- You don’t control your emotions.

Example

“Who do you think you are to tell me that I have to wait until next year to get help for Janice? That’s not good enough. If I have to wait, I’ll see you in court.”

Assertive Is just right.

- You focus on problems and solutions.
- You express yourself honestly and openly.
- You express your feelings while controlling anger.

Example

“I think it would be a mistake to wait until next year to begin Janice’s speech therapy. The school should find a private specialist to help her now. As soon as the school’s speech therapist has an opening, we can let her continue Janice’s services.”

How can I be assertive?

You can be assertive by saying what you want or need or believe in an honest way that respects the rights of others. You can learn about your rights and remind others of their responsibilities. You can focus on solving problems.

Will people think I'm rude if I'm assertive?

Assertive people are not rude. They let others know what they are thinking, but they don't attack others or their ideas.

Do I have to get "tough" to be assertive?

Assertive people are "tough" only in the sense that they are firm and self-confident. They stand up for what they know is right, but they don't bully others. They don't say "yes" unless they mean it, but they are not stubborn.

Why is it hard to be assertive?

It is hard to be assertive because many people feel guilty, lack self-confidence, or are in the habit of letting others tell them what to do. You can learn to be assertive.

Here are a few tips:

- Say what you really want to say.
- Ask and suggest, don't whine or plead.
- Relax, stay calm.
- Be firm, not angry or stubborn.
- Focus on your goal.

WRITING LETTERS

Letters are a good way to get things done. They help families tell others what is going on or what they want. They can be a record of a decision or agreement. Always remember to keep a copy of each letter for your own personal files.

What kinds of letters should I write?

You can write letters to ask for services, state a problem, ask questions, or tell others your ideas or feelings.

What should I put in a letter?

Letters do not have to be fancy or clever. They just have to have certain information. Following is a list of things to put in your letters:

- The date the letter is written
- Your name and address (phone number if you are asking someone to call you)
- Name and address of the person you are writing to
- Your child's name
- Information about the challenges or issue
- Any questions or requests
- A restatement of any decisions or agreements
- When you expect to hear back
- Thank you

SAMPLE LETTER ASKING FOR AN EVALUATION

Your Name

Your Address

City, State, Zip

Date

Name of Principal

Name of School

Address of School

City, State, Zip

Dear (principal's name),

I am a parent of (child's name). My child is having problems with his schoolwork. I think he/she may have special needs. I would like for him/her to be tested to find out if he/she is eligible for special education or related services.

I would appreciate hearing from you within the next five business days. Please call me at (phone number) or email me at (your email address) if you have any questions about my request.

Sincerely,

Your name

SAMPLE LETTER REQUESTING AN ASSESSMENT

Your Name

Your Address

Your City, State, Zip Code

Name of Special Education Director or Your Child's Program Specialist

Name of District

District Address District City, State, Zip Code

Regarding: Your Child's Name

I am writing to request an assessment for my child, (your child's name) to determine if he/she is eligible for special education services. He/she is (age) years old and attends (name of school).

I am requesting assessments in the areas of (speech, occupational therapy, academics, behavior, etc.) for the following reason(s): (Be as specific as possible-such as "he/she is not clear when speaking and no one else can understand"; "his/her handwriting is very poor for his/her age"; "he/she cannot copy a line that I draw as an example"; "he/she becomes angry easily and sometimes lashes out physically").

I understand that all areas of difficulty should be assessed for whatever services that might be available to accommodate (your child's name) disability. (If your child has a diagnosis, include it here, i.e. "My child has been diagnosed by his pediatrician with autism).

Following the assessment and team review of the results, should my child be found to have a disability but not qualify for special education services under IDEA, I also request that accommodations be made for him/her under Section 504 of the Rehabilitation Act of 1973. For this reason, I also request that the Section 504 Coordinator for (your district) be present at the initial IEP meeting to discuss recommendations for accommodations.

I look forward to meeting with the assessment team as soon as the assessments are completed so that we can discuss the results and plan for my child's education. Finally, I would like copies of the assessments report(s) at least one week prior to the IEP meeting so that I may review them to be better prepared for the meeting.

You may mail them at my address above or you can send them to me electronically at my email address which is (your email address). If you need to speak with me, please call me at (your phone number).

Sincerely,

Your Name

SAMPLE LETTER DOCUMENTING A PHONE CALL OR EMAIL

Your Name

Your address

City, State, Zip

Name of Person

Job Title

Address

City, State, Zip

Dear (person's name),

Thank you for talking with me today about (child's name). I understand that you are concerned about (state child's name). As I said on the phone, I am concerned about (state concern). You feel that (name the person/people) will help. The (name the support-mental health provider, court counselor, social worker, etc.) agreed to (state what they said they would do). I also said that I would (state what you would do).

Thank you for your time and help,

Sincerely,

Your name

SAMPLE LETTER ASKING FOR INFORMATION

Your Name

Your Address

City, State, Zip

Date

Name of Person

Job Title Address

City, State, Zip

Dear Dr. _____,

My (child's name) has been taking (name of medication) that you prescribed to help control his/her mood swings. The medication is making him/her sleepy at school. He/she seems less nervous but is sleepy all the time and can't get his/her school work done.

I would like written information on other medication options for controlling his/her mood swings. I would like this information prior to our next appointment so we can review and discuss.

Please send information to my address above or by email (your email address) as soon as possible. You may call me at home (phone number) or email me if you have any questions.

Sincerely,

Your name

SAMPLE LETTER ASKING FOR SCHOOL SERVICES

Your Name

Your Address

City, State, Zip

Date

Name of Principal

Name of School

Address of School

City, State, Zip

Dear (principal's name),

I am writing to ask for (speech/or whatever type therapy) for (child's name). (Speech therapy) is part of my child's IEP, but he/she has not received that service yet. Please let me know when his/her (speech therapy) will begin.

Without (speech therapy) my child is not receiving an "appropriate" education to meet his/her needs. I understand the school is required to meet my child's educational needs through his/her IEP. I would like to meet with you to discuss the available options.

I hope to hear from you within 5 business days. The best time to call me at (phone number) is before 8:00am or after 7:00pm. If you cannot reach me by phone, please send me an email response at (your email address).

Thank you for your help.

Sincerely,

Your name



Good record keeping
can be as valuable as a
good friend.

Remember that it is very important to develop a file with important information about your child's care. This can help you and your child become excellent historians about previous services, what worked and what didn't. The file will also serve as a timeline for requesting and receiving services. Nothing helps with accountability like documentation. Remember to write it down and keep it where you can find it.

Documentation could include things like letters written and received; emails written and received; copies of all assessments requested and completed; report cards, copies of IEP's and IEP invitation letters. Any and all correspondence regarding your child/youth should be copied and placed in a file. Keep your file in a safe place and always know where it is when you need it. Good record keeping can be as valuable as a good friend.

Also, remember there are many laws that protect children with special challenges and needs. The school system has several important ones related to the education of a special needs child. Some of them are:

IDEA – Individual Disabilities Education Act, which protects the rights of children with disabilities.

FAPE – Free and Appropriate Public Education Act guarantees that a child will receive a free public education.

NCLB - No Child Left Behind which is a Federal law regulating the education of children, showed where students made improvements and where they needed additional supports.

ESSA - Every Student Succeeds Act focused on the goal of fully preparing all students for success in college and careers as well as supporting success of the schools.

It is very important that you as a parent or caregiver learn what each of these laws as well as others say, so you can provide a strong advocacy role for your child.

NC Families United will be able to help you understand laws that protect your child's rights in school as well as other child serving organizations.

SOC'S GROWTH IN OTHER CHILD-SERVING SYSTEMS

System of Care is the North Carolina Child-Serving Systems Way

Session Law 2001-424 section 21.60 legislation pronounced the SOC approach for services to children and their families statewide under the Comprehensive Treatment Services program. This legislation outlined the essential program elements and set guiding principles for the provision of services for this SOC approach. A state Memorandum of Agreement (MoA) repeating those elements and principles was co-signed by the top leaders of the key child-serving systems. Then in order for communities to access funds intended for children with moderate and severe SED (Severe Emotional Disturbance) who required coordinated care across child-serving systems, they had to establish local MoAs modeled on the State MoA and establish local SOC collaboratives of local child-serving leaders to coordinate across systems at the local level. The state MoA expired in 2008.

However, people who work in child-serving systems at the local and state level, understand that ultimately, effective service with positive outcomes for children, youth and their families will only happen through strong cross-agency collaborations. The key child-serving systems supported the initial development of the Child and Family Team curriculum that is online and managed by NC Families United. The State Collaborative updated the CFT 01 curriculum in 2017. This included facilitating input from each of the key child-serving systems. NC State Collaborative is now in the process of updating and adding to a whole menu of trainings for agencies, families, and any other stakeholders in children's services. The newly developed Family, Youth and Cross Systems Resource Center under NC Families United will host a variety of family-driven, youth-guided, co-lead trainings for family, youth and agencies.

Cross-systems team planning is an integral part of each of the child-serving systems in North Carolina. Even as each of the service delivery systems have continued to evolve over the past 20 years, coordination across systems remains an important goal for each. Fortunately, there continues to be opportunities to build cross-system partnerships that will deepen NC SOC efforts.

Below we briefly outline the opportunities for continued evolution of NC SOC and the current system reforms underway within each of the service delivery systems.

Child Welfare

Child Welfare Legislation

Session Law 2017-41 Summary (information in brackets contain additional contextual information)

- 1) Establishes social services regional supervision and collaboration
- 2) Reforms the State child welfare system
- 3) Improves accountability and state oversight of the child welfare system
- 4) Requires written agreements, corrective action, and state intervention with social services departments (effective March 1, 2020)
- 5) Creates (optional) regional social services departments (effective March 1, 2017)
- 6) Establishes a child well-being transformation council to improve coordination, collaboration, and communication among child-serving agencies
- 7) Establishes a pilot program to help youth in substitute care obtain drivers licenses
- 8) Establishes a pilot program to authorize a waiver of the employment requirement for foster parents with children receiving intensive alternative family treatment [the state does not have an employment requirement]
- 9) Reduces the time a parent has to appeal from a termination of parental rights order (from 180 days to 65 days beginning January 1, 2019)
- 10) Reduces the time for foster care licensure approval (within 3 months of receiving application (to Black Mountain Office)
- 11) Requires child protective service observation before physical custody of a child may be returned to a parent, guardian, custodian or caretaker from whom the child was removed (two visits, seven days apart, at least one hour long)

[http://www.ncleg.net/Applications/Dashboard/Chamber/Services/BillSummary.aspx?sSessionCode=2017&sBarcode=H630-SMTV-32\(e3\)-v-2](http://www.ncleg.net/Applications/Dashboard/Chamber/Services/BillSummary.aspx?sSessionCode=2017&sBarcode=H630-SMTV-32(e3)-v-2)

Education

The Elementary and Secondary Education Act of 1965, as amended by the Every Student Succeeds Act, Consolidated State Plan (also see Frank Rider's PowerPoint -https://gucchdtacenter.georgetown.edu/early_childhood_SOC.html).

School Mental Health Policy:

Department of Public Instruction (DPI) invested in whole school, whole community, whole child model. The goal is to provide access to all DPI students a full array of services/strategies in a comprehensive mental health services system.

- Each Local Education Agency (LEA) shall develop and implement a plan for assessing and improving on effectiveness of existing supports for mental health and substance use needs of its student population.
- Plan must address a continuum of services that consists of these elements:
 - universal prevention
 - early intervention services
 - referral, treatment, and re-entry

Each LEA plan shall provide for engagement of relevant stakeholders, including families, students, community providers, and cross-system partners.

Goal: Build school, community, family partnerships to create and sustain coordinated MH and substance use supports and services for students.

Early Childhood

(refer to August 2017 update from the NC Institute of Medicine - NCIOM)

March 2015 Task Force on Essentials for Childhood

Establish Coordinated State Leadership Efforts to Address Essentials for Childhood through a Collective Impact Framework at the North Carolina Institute of Medicine website ([search Catherine Jayner's publication on the Task Force on Essentials for Childhood](#)).

<http://nciom.org/task-force-on-essentials-for-childhood/2>

NC Essentials for Childhood is a statewide collaborative initiative to prevent child maltreatment and promote child and family well-being. Using the principles of collective impact, the Essentials for Childhood leadership and working groups are working to implement the recommendations of the 2014 NCIOM (NC Institute of Medicine) Task Force on Essentials for Childhood.

Juvenile Justice

Juvenile Justice Reinvestment Act “Raise the Age”

The State works with Juvenile Justice regarding the provision of services for youth with Substance Use, Mental Health, as well as Intellectual and Developmental Disabilities for youth in and re-entering the community.

State Level - There is a Juvenile Justice Behavioral Health State Team consisting of representation from DMH/DD/SAS, DPI, DSS, and JJ that meet to address needs for state and local partners.

Local Level – (which DMH/DD/SAS oversees) The Juvenile Justice Substance Abuse Mental Health Partnerships (JJSAMHP) are local teams across NC working together to deliver effective, family-centered services and supports for Juvenile Justice involved youth with substance use, mental health challenges, or facing issues in both areas. These teams consist of three (3) parts, LME-MCO representatives, Juvenile Justice Court Counselor Chiefs, and local providers, and require an organized person-centered system that operates under system of care principles. Currently there are 20 teams across the state. Teams focus their work around the five (5) domains of JJSAMHP; which include screening/referral, assessment, engagement, Evidence Based Treatment, and Recovery oriented systems of care (beyond treatment).

Legislation: House Bill 280 passed. Juvenile Justice Reinvestment Act “Raise the Age” <http://www.ncleg.net/gascripts/BillLookUp/BillLookUp.pl?Session=2017&BillID=H280>

Substance Use

Link this to SOC opportunity: On May 1, 2017, North Carolina received \$15,586,724 to address the opioid crisis through the 21st Century Cures Act, State Targeted Response to the Opioid Crisis Grants.

The Substance Abuse and Mental Health Services Administration (SAMHSA) awarded the grant to the N.C. Department of Health and Human Services (DHHS) Division of Mental Health, Developmental Disabilities and Substance Abuse Services to increase access to prevention, treatment and recovery supports, reducing unmet treatment need, and reducing opioid-related overdoses and deaths.

- Eighty percent of these funds must support outreach, engagement, treatment and recovery services
- Grant funds are expected to serve at least 1,460 individuals in the first year

This grant will allow North Carolina to serve a greater number of individuals experiencing opioid use disorders and expand the number of medication-assisted treatment and opioid use disorder treatment providers into the future.

For more information on exciting initiatives in NC for children and their families, and laws that help support children and their families, see the following websites:

- For more information on laws that protect children in public education and Positive Behavioral Supports you can visit the Department of Public Instruction's web site: www.ncpublicschools.org and information on Positive Behavior Supports Visit:
<http://www.ncpublicschools.org/docs/positivebehavior/data/evaluation/pbs-eval-report.pdf>
http://classic.ncmedicaljournal.com/wpcontent/uploads/2012/09/NCMJ_73506_FINAL.pdf
<http://www.ncpublicschools.org/docs/positivebehavior/data/evaluation/2008-09/eval-report.pdf>
www.ncpublicschools.org/ec/behavioral/initiatives/postivebehavior/programs
- For information about Children receiving Medicaid as an entitlement to services visit the Department of Health and Human Services Division of Medical Assistance at their web site:
www.dma.ncdhhs.gov

- For more information about the State Mental Health Plan, Service Definition, Person/Family- Centered Planning, System of Care, Community Collaboratives and the State Collaborative please visit the Department of Health and Human Services Division of Mental Health, Developmental Disabilities, and Substance Abuse Services at their web site: www.dhhs.state.nc.us/mhddsas and click onto **Child and Family** www.dhhs.state.nc.us/mhddsas/childandfamily/index
- For more information about the Department of Health and Human Services, Division of Social Services SOC Child Welfare Grant and Multiple Response System go to their website: www.ncdhhs.gov
- For more information about the Administrative Office of the Courts go to their website: www.nccourts.org
- For more information about the Division of Public Health go to their website: www.ncpublichealth.com click onto Women's and Children's Health to learn more about School Health Programs and other services
- For more information about the Department of Juvenile Justice Delinquency and Prevention's community-based care, moving from punishment to treatment, go to their website at: www.ncdjdp.org click on Community Programs
- For more information about laws that help protect the rights of children and families, visit the Bazelon Center for Mental Health Law website at: <http://www.bazelon.org/>



AGENCIES & ORGANIZATIONS

Listed are a few State and National Agencies and Organizations. Contact your local LME/MCO for a complete list and available resources in your county.

Autism Society of North Carolina

505 Oberlin Rd., Suite 230
Raleigh, NC 27605-1345
919-743-0204
800-442-2762
www.autismsociety-nc.org

Benchmarks

2609 Atlantic Avenue, Suite 105
Raleigh, NC 27604
919-828-1864
www.benchmarksn.org

Brain Injury Association of NC

6604 Six Forks Road
Raleigh, NC 27615
919-833-9634
800-377-1464
www.bianc.net

Community Care of NC

2300 Rexwoods Drive, Suite 100
Raleigh, NC 27607
919-745-2350
<https://www.communitycarenc.org/>

Disability Rights North Carolina

3724 National Drive, Suite 100,

Raleigh, NC 27612

877-235-4210

919-856-2195

www.disabilityrightsncc.org

Easter Seals UCP North Carolina

5171 Glenwood Ave. Ste. 211

Raleigh, NC 27612

800-662-7119

919-783-8898

<http://www.easterseals.com/NCVA/>

Exceptional Children's Assistance Center (ECAC)

907 Barra Row St. 102/103 Davidson, NC 28036

800-962-6817

704-892-1321

www.ecac-parentcenter.org

Family Support Network of NC

CB#7340, UNC

Chapel Hill, NC 27599-7340

Access Family Support

800-853-0042

www.fsnncc.org

Learning Disabilities Association of NC

PO Box 3832

Chapel Hill, NC 27515 919-929-3621

LDA.of.northcarolina @gmail.com

<http://www.ldanc.org>

Legal Aid of NC

224 S. Dawson St.

Raleigh, NC 27611

866-219-5262

<http://www.legalaidnc.org/>

NAMI- NC Alliance for the Mentally Ill

309 W Millbrook Rd Ste 121

Raleigh, NC 27609

Telephone: 919.788.0801 ext. 2;

Helpline: 800-451-9682

www.naminc.org

NC Child-Child Advocacy Institute

3101 Poplarwood Ct. Ste. 300 Raleigh, NC 27604

919-834-6623

<http://www.ncchild.org/>

NC Council on Developmental Disabilities

3125 Poplarwood Court, Suite 200

Raleigh, NC 27604

800-357-6916

919-850-2901

<https://www.nccdd.org/>

NC Coalition Against Domestic Violence

3710 University Drive, Suite 140
Durham, NC 27707
919-956-9124
Hotline: 800-799-7233
<https://nccadv.org/>

SAYSO

www.saysoinc.org/
919-384-1457

NC Families United

206 East Elm Street
Graham, NC 27253
336/395.8828
www.ncfamiliesunited.org

TEACCH (Autism)

100 Renee Lynne Court
Carrboro, NC 27510
919-966-2174
<https://teacch.com>

The ARC of North Carolina

343 East Six Forks Rd, Suite 320
Raleigh, NC 27609
919-782-4632
800-662-8706
www.arcnc.org

Youth M.O.V.E.

www.ncfamiliesunited.org
336-395-8828

NATIONAL ORGANIZATIONS

National Federation of Families for Children's Mental Health

12320 Parklawn Drive
Rockville, MD 20852
240-403-1901
www.ffcmh.org

National Alliance on Mental Illness

3803 N. Fairfax Drive Ste. 100
Arlington, VA 22203
800-950-6264
703-524-7600
www.nami.org

National Mental Health Association aka Mental Health America

Citizens Commission on Human Rights International

6616 Sunset Blvd.
Los Angeles, CA 90028
323-467-4242
800-869-2247
<https://www.cchrint.org/>

National Institute of Mental Health

Science Writing, Press, and Dissemination Branch

6001 Executive Boulevard, Room 6200, MSC 9663
Bethesda, MD 20892-9663
1-866-615-6464 (toll-free)
1-301-443-8431 (TTY)
1-866-415-8051 (TTY toll-free)
<https://www.nimh.nih.gov/>

SAMHSA/Substance Abuse

Mental Health Services Administration

5600 Fishers Lane

Rockville, MD 20857

877-726-4727

www.samhsa.gov

ACRONYMS & TERMS

A

ABC	Attachment Bio-Behavioral Catch-up
ACA	Affordable Care Act (Obama Care)
ACE's	Adverse Childhood Experiences
ACT	Assertive Community Team
ADA	American Disabilities Act
ADATC	Alcohol and Drug Abuse Treatment Center
ADD	Attention Deficit Disorder
ADETS	Alcohol and Drug Education Traffic School
ADHD	Attention Deficit Hyperactive Disorder
AG	Academically Gifted
AHCA	American Health Care Act (Trump Care)
AHEC	Area Health Education Center
ALGEE	Action Plan for Mental Health First Aid
AOC	Administrative Office of the Courts
AMI	Alliance for the Mentally Ill
ARC	Association for Retarded Citizens
ASAM	American Society of Addictive Medicine
ASD	Autism Spectrum Disorder
B	
B3	Services funded through LME/MCO savings reinvested to serve Medicaid eligible I/DD individuals
BIP	Behavioral Intervention Plan
BED	Behavioral/Emotional Disorder (public schools)
BH	Behavioral Health

C

CAP	Community Alternatives Program
CAFAS	Child and Adolescent Functional Assessment Scale
CASSP	Child and Adolescent Service System Program
CBT	Cognitive Behavioral Therapy
CC	Community Collaborative
CCA	Comprehensive Clinical Assessment
CC4C	Care Coordination for Children
CFAC	Consumer and Family Advisory Committee
CFACE	Center for Family and Community Engagement
CCNC	Community Care of North Carolina
CCSW	Certified Clinical Social Worker
CDSA	Children's Development Services Agency
CEC	Council for Exceptional Children
CFAC	Consumer and Family Advisory Committee
CFP	Child and Family Plan
CFT	Child and Family Team
CHIP	Children's Health Insurance Program
CIS	Community in Schools
CIT	Crisis Intervention Team
CJO	Criminal Justice Offender – Child or Adult Population
CMH	Child Mental Health
CMS	Centers for Medicare/Medicaid Services
COD	Co-Occurring Disorders
CPS	Child Protective Services
CPSP	Certified Parent Support Provider
CSAT	Center for Substance Abuse Treatment

D

DACJJ	Division of Adult Correction & Juvenile Justice
DCD	Division of Child Development DD Developmental Disabilities
DHHS	Division of Health and Human Services
DJJDP	Division of Juvenile Justice and Delinquency Prevention
DMA	Division of Medical Assistance
DMH/DD/SAS	Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
DOC	Department Of Correction
DOH	Department Of Health (State)
DPH	Department of Public Health (County)
DPI	Department of Public Instruction (State)
DSDHH	Division of Services for the Death and Hard of Hearing (State)
DSM-IV	Diagnostic and Statistics Manual (State)
DSS	Division of Social Services (State)
DWI	Driving While Impaired
DUI	Driving Under Influence
DV	Domestic Violence
DX	Diagnosis

E

EBD	Emotionally or Behaviorally Disturbed
EBP	Evidence Based Practice
EBT	Evidenced Based Treatment
ECAC	Exceptional Children's Assistance Center
ED	Emotionally Disturbed
EMDR	Eye Motion Desensitization and Reprocessing
EOC	End Of Course (DPI)
EOG	End Of Grade (DPI)
EPSDT	Early Periodic Screening, Diagnosis and Treatment
ESEA	Elementary and Secondary Education Act

ESL	English as a Second Language
F	
FPC	Family Partner Coordinator
FAPE	Free and Appropriate Public Education
FFT	Family Functional Therapy
FAN	Family Advocacy Network
FCT	Family Centered Treatment
FFCMH	Federation Families Children's Mental Health
FES	FES Family Empowerment Scale
FFS	Fee For Service
FSN	Family Support Network
FSP	Family Support Partner
FREDLA	Family Run Executive Director Leadership Association
G	
GAL	Guardian ad Litem
G.S.	General Statute
GAF	Global Assessment of Functioning
H	
HC	Health Check HC Health Choice
HCBS	Home and Community Based Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health Maintenance Organization
HOM	Homeless Child or Adult Substance Abuse Population
HUD	Housing and Urban Development
I	
IAFT	Intensive Alternative Family Treatment
ICC	Interagency Coordinating Council

ICD	International Classification of Diseases
ICF	Intermediate Care Facility
I/DD	Intellectual Developmental Disability
IDEA	Individuals with Disabilities Education Act
IEP	Individualized Education Program
IFSP	Individual Family Services Plan
IIH	Intensive In-Home
IPRS	Integrated Payment and Reporting System
IT	Information Technology
I & R	Information and Referral
IY	Incredible Years
J	
JCAHO	Joint Commission for Accreditation of Healthcare Organizations
JCC	Juvenile Court Counselor
JJ	Juvenile Justice
JCPC	Juvenile Crime Prevention Council
JJSAMHP	Juvenile Justice Substance Abuse Mental Health Partnership
L	
LCSW	Licensed Clinical Social Worker
LGBTQ-2S	Lesbian, Gay, Bisexual, Transgender, Questioning, 2 Spirited
LEA	Local Education Agency (Local Public-School Systems)
LEP	Limited English Proficient
LINKS	Independent Living Services for Youth in Foster Care
LME	Local Management Entity
LOC	Legislative Oversight Committee
LOC	Level Of Care
LRE	Least Restrictive Environment

M

MAJORS	Managing Access for Juvenile Offender Resources and Services
MCO	Managed Care Organization
MH	Mental Health
MHA	Mental Health America
MHA	Mental Health Association
MHFA	Mental Health First Aid
MH/DD/SA	Mental Health, Developmental Disability, Substance Use
MHTF	Mental Health Trust Fund
MMIS	Medicaid Management Information System
MOA	Memorandum Of Agreement
MOU	Memorandum Of Understanding
MTFC	Multi-Dimensional Treatment Foster Care
MST	Multi-Systemic Therapy
MSW	Master's Degree in Social Work

N

NAMI	National Alliance on Mental Illness
NAMINC	North Carolina Alliance on Mental Illness
NCCDD	North Carolina Council on Developmental Disabilities
NCTSN	National Child Traumatic Stress Network
NCFU	North Carolina Families United
NCHC	North Carolina Health Choice
NC TOPPS	North Carolina Treatment Outcomes and Program Performance System
NC WISE	North Carolina Window of Information on Student Education
NIMH	National Institute of Mental Health
NMHA	National Mental Health Association

O**OCD** Obsessive-Compulsive Disorder**ODD** Oppositional Defiant Disorder**OHI** Other Health Impaired**OT** Occupational Therapy**P****PAT** Parents As Teachers**PBIS** Positive Behavioral Intervention & Supports**PCP** Person Centered Plan**PCP** Primary Care Physician**PCIT** Parent Child Interactive Therapy**PEP** Personal Education Plan (Public Schools)**PPO** Preferred Provider Organization**PPAT** Permanency Planning Action Team**PRTF** Psychiatric Residential Treatment Facility**PTA** Parent-Teacher Association**PT** Physical Therapy**PTO** Parent and Teachers Organization**PTSD** Post Traumatic Stress Disorder**Q****QA** Quality Assurance**QI** Quality Improvement**QM** Quality Management**QPR** Question, Persuade and Refer

R

RFA	Request For Application
RFI	Request For Information
RFP	Request For Proposal
RPC	Resource Parent Curriculum (Caring for Children Who Have Experienced Trauma)
RRC	Regional Resource Centers (Special Education)
RX	Prescription

S

SAD	Substance Abuse Disorder – Child
SAMHSA	Substance Abuse and Mental Health Services Administration
SA	Substance Abuse
SAYSO	Strong Able Youth Speaking Out
SBI	State Bureau of Investigation
SCFAC	State Consumer and Family Advisory Committee
SCS	Standard Course of Study (DPI)
SED	Seriously Emotionally Disturbed
SIP	School Improvement Plan
SIMS	Student Information Management System (DPI)
SMHRCY	State Mental Health Representatives for Children and Youth
SNAP	Support Needs Assessment Profile
SNAP	Supplemental Nutrition Assistance Program
SIS	Supports Intensity Scale
SOC	System Of Care
SOC-EX	System Of Care Expansion
SOS	State Operated Services
SOW	Scope Of Work
SPARCS	Structured Psychotherapy for Adolescents Recovering from Chronic Stress
SPMI	Sever and Persistent Mental Illness
SRO	

SS	Social Security
SSI	Supplemental Security Income
STS	Secondary Traumatic Stress
T	
TANF	Temporary Assistance for Needy Families
TAR	Treatment Authorization Request
TASK	Treatment Alternatives for Sexualized Kids
TBI	Traumatic Brain Injury
TEACCH	Treatment and Education of Autistic and Related Communication Handicapped Children
TF-CBT	Trauma-Focused Cognitive Behavioral Therapy
TMH	Trainable Mentally Handicapped
TF-CBT	Trauma Focused-Cognitive Behavior Therapy
Title IV-E	Foster Care & Adoption Assistance Programs (section of Social Security Act)
Title XIX	Medicaid (Section of the Social Security Act)
Title XVIII	Medicare (Section of the Social Security Act)
TPR	Termination of Parental Rights
Triple P	Positive Parenting Practice
TTY	Text Telephones
TX	Treatment
U	
UM	Utilization Management
V	
VI	Visually Impaired (also VH)
VR	Vocational Rehabilitation
W	
WIC	Women, Infants, and Children (food and nutrition service)
WRAP	Wellness Recovery Action Plan
Y	
YDC	Youth Development Center
Youth M.O.V.E.	Motivating Others thru Voices of Experience



WORDS TO KNOW

Access

Availability of treatments, services and supports that families know how and where to obtain, with no system barriers or obstacles.

Achievement Test

A test that measures what a child has learned. Scores are reported in age or grade equivalents.

Acting Out

Feelings/emotions that may be expressed by self-abusive, aggressive, violent and/or disruptive behavior. This may be a behavior that is seen when a child's needs are not being met.

Adaptive Behavior

A wide range of skills used by a child to meet his/her everyday needs.

Advance Directive

A legal document that allows families to plan their own mental health care in the event the individual loses the capacity to effectively make decisions.

Advocacy

The process of actively supporting the cause of an individual (case advocacy) or group (class advocacy), speaking or writing in favor of a person or family.

Ex. Family partner, youth partner or adult peer support.

Affective Disorder

A disorder of mood (feeling, emotion). Refers to a disturbance of mood and other symptoms that occur together for a minimal duration of time and are not due to other physical or mental illness.

Aftercare

Supervision or treatment provided to individual for a limited time after release from a residential treatment program or hospitalization.

American Society of Addiction Medicine (ASAM)

An international organization of physicians dedicated to improving the treatment of people with substance use disorders by educating physicians and medical students, promoting research and prevention, and informing the medical community and the public about issues related to substance use.

Some of the information in this glossary is taken from the text of "Taking Charge"; the NC Collaborative for Children, Youth and Families; SAMSHA; Cardinal Innovations; and NC Families United. This list is not exhaustive.

Anxiety

Feelings of uneasiness or bouts of terror.

Anxiety Disorder

Is anxiety that interferes with a persons work, school, activities, relationships and daily living.

Appeals Panel

Request or reference to some person or authority for a decision, etc.

State MH/DD/SA appeals panel established under NC G.S. 371 and G.S. 122c-151.4

Appropriate Education

An individual education program specially designed to meet the unique needs of a child who has a disability.

Architectural Barrier

Any part of a building or grounds that keeps a handicapped person from having normal, easy access.

Assessment/Evaluation

Test, interviews, observations used to gather information to help write a plan and identify services or interventions for a child(ren) and family.

Attachment Disorder

An attachment disorder is a condition in which individuals have difficulty forming loving, lasting, intimate relationships.

Attention Deficit Hyperactivity Disorder

A range of behavioral disorders occurring primarily in children, including but not limited to symptoms such as poor concentration, hyperactivity or hyper-focused and impulsivity.

Autism

A mental health/developmental disability, present from early children, characterized by difficulty in communicating and forming relationships with other people and in using language and abstract concepts.

Behavior Modification

A method of changing behaviors by teaching and reinforcing new behaviors. Behavior modification is done by setting goals and using a specific plan to reach those goals.

Behavioral Objectives

Steps used to reach identified goals. Describes what a child will be able to do and how he will learn to do it. Behavioral objectives also state how the learning will be measured and the criteria for success.

Behaviorally-Emotionally Disorder (Public School)

A disability that involves how a person behaves and acts towards others. Some common symptoms are: cannot make or keep friends; does not act his age or in ways that fit the activity or situation; has general and ongoing moods of sadness or depression; has difficulty learning; has other personal or school-related problems.

Bipolar Disorder

A mood disorder with elevated mood often accompanied by major depressive episodes.

Block Grant

Funds received from the federal government (or others), in a lump sum, for services specified in an application plan that meet the intent of the block grant purpose.

Care Coordination

A coordination of services for children and families who have complex needs and are at high risk of out of home placement. These services should be family driven and work as a GPS for the family.

Case Management

Ensures that multiple services are delivered in a coordinated and therapeutic manner so children and their families can move through the service system in line with their family-driven needs. It is more intense than care coordination.

Centers for Medicare and Medicaid Services (CMS)

The federal agency responsible for overseeing the Medicare and Medicaid programs

Child and Family Plan (CFP)

A family-driven plan that is based on strengths, goals and needs identified by the family. The plan is developed through the child and family team.

Child and Family Team (CFT)

Child and Family Teams are family members and their identified supports that come together to create, implement and update a plan with the child, youth and family. The plan builds on the strengths of the child, youth and family and addresses their needs, desires and dreams.

Collaboration

A partnership between families, agencies and/or community stakeholders to reach desired outcomes.

Community-Based Services

The practice of having services accessible to families in the least restrictive setting possible, as well as management and decision-making responsibility in the local community.

Consumer and Family Advisory Committee (CFAC)

A committee of consumers and family members who receive mental health, I/DD or substance use services for themselves or their families. A self-governing committee that serves as an advisor to the state DHHS or at the local level to the MCO and their board of directors.

Cultural Responsiveness

A process that promotes development of skills, beliefs, attitudes, habits, behaviors and policies that enable individuals and groups to interact, showing acceptance and understanding of others.

Delinquency

Violation of law by a child or youth (usually under 18).

Depression

A type of mood disorder characterized by low or irritable mood or loss of interest or pleasure in almost all activities over a period of time.

Developmental Disorders

Disorders that have predominant disturbances in normal development of language, motor, cognitive and/or motor skills.

Dual Diagnosis

A diagnosis of an emotional or behavioral disorder and another disorder such as developmental disability, drug and/or alcohol use or a mental illness.

Due Process Hearing

A formal legal proceeding presided over by an impartial public official who listens to both sides of the dispute and renders a decision based upon the law

Early Periodic Screening, Diagnostic and Treatment Services (EPSDT)

Services provided under Medicaid to children under age 21 to determine the need for mental health, developmental disabilities or substance abuse services. Providers are required to provide needed service identified through screening.

Emotional or Behavioral Disorder (or Disability)

An inability to build or maintain satisfactory interpersonal relationships with peers and/or teachers. These behaviors may disrupt his/her academic and/or developmental progress, and family relationships. This term is often used in the integrated health care system.

End of Course Tests (Mid-terms)

Test that are designed to assess the competencies defined by the NC Standard Course of Study for each of the following courses: Algebra I, Algebra II, English I, Biology, Chemistry, Geometry, Physical Science, Physics, Civics and Economics, and US History. Tests are taken during the last 10 days of school or the equivalent for alternative schedules.

End of Grade Tests

Tests in reading and mathematics are taken by students in grades 3-8 during the last three weeks of the school year.

Enhanced Benefits

A state funded service for Mental health, developmental disabilities, and/or substance abuse services that may be provided for those individuals meeting the definition developed by LME/MCO and their CFAC.

Evaluation

More in-depth than an assessment, examination of specific needs or concerns by a specialist using evidenced-based evaluation tools.

Evidence Based Practices

The integration of clinical expertise, patient values, and the best research evidence into the decision-making process for patient care.

Exceptional Children (public schools)

An inclusive term that refers to children with learning and/or behavior problems, physical disabilities, sensory impairments, and/or those who are intellectually gifted or have special talents.

Family Advocate

A community resident and/or a family member who provides support to families who enter the service delivery system. This support may be emotional support, education about services, assistance linking to and working directly with service providers, and advocacy within the service system to help families build on their unique strengths and meet their individualized needs.

Family Partner (FP)

A Family Partner is a person who can articulate lessons learned from his/her own lived experience *parenting a child/youth with social/emotional or behavioral challenges and has specialized training to assist and support families raising children/youth who experience social/emotional, developmental, behavioral, substance use, or mental illness concerns. A Family Partner collaborates with child and family serving systems and Family and Youth Organizations to improve family outcomes and strives to eliminate stigma and discrimination.

(*parenting a child is defined as the primary caretaker of a child for an extended period of time who has decision making authority for that child).

Family Partner Coordinator (FPC)

A Family Partner Coordinator is a Family Partner as defined above who also takes on a greater role in their local communities. They Partner not only with families, but also with the System of Care Coordinators and stakeholders in the community. Other responsibilities of FPC would include, but not limited to would be:

- Recruiting and mentoring Family Partners
- Advocating SOC values and principles when addressing the needs of families and insuring fidelity to the implementation of the Child and Family Team process for families.
- Providing training and co-training, education and coaching to youth and families, community and professional stakeholders, service providers, business communities and family/natural supports while promoting family voice and choice.
- Collaborating with the preparation of CFT's, following up with families, partnering with SOC Coordinators in linking families with services/resources.
- Sitting on local and state collaboratives, boards, commissions, councils and community meetings where decisions are being made that impacts the youth and families in their communities to promote family voice and a family perspective.

Family Support

Persons identified by the family as either family members, natural supports or others who provide the necessary help for furthering quality of life, reaching personal life goals or recovery.

Free Appropriate Public Education (FAPE)

A legal guarantee that no child can be denied a public education because of a disability. The public education must be at no cost to parents, be based on the child's needs, and meet the standards of the state education agency.

Family Run Organization

An organization that makes its own decisions and operates independently and has a 51% Board of Directors and staff that are or have been parents or primary caretakers of children ages 0-26 within their disability specialty. They provide family driven voice and choice in services and policy making. family members that provide family voice and choice and delivers advocacy services.

Health Choice

The health insurance program for children in North Carolina that provides comprehensive health insurance coverage to uninsured low-income children. Financing comes from a mix of federal, state, and other funds.

Health Insurance Portability and Accountability Act (HIPAA)

A federal Act that provides privacy standards to protect patient's medical records and other health information provided to health plans, doctors, hospitals and other health care providers. The Act aims to make sure that prospective or current service consumer are not discriminated against based on health status.

Inclusion

An educational option for students with disabilities to be educated in a regular classroom in their neighborhood school with all necessary supports provided so that the student can participate fully.

Individualized Education Program (IEP)

A written plan that is family-driven for a child with special education needs. The plan is based on results from an evaluation and is developed by a team that includes the child's parents, teachers, other school representatives, specialists, and the child when appropriate. The parents make the final decision of the time, place and who may attend this meeting.

Informed consent

When you give permission for a service and it has been explained to you in a language/way you can understand.

Intelligence Quotient (I.Q.)

A score from a standardized test of mental ability. I.Q. is found by relating the person's test score to his age.

Integrated Health Care

Combining mental health, substance abuse, and primary care services to produce the best outcomes for families and proves the most effective approach to caring for people with multiple healthcare needs.

Least Restrictive Environment (LRE)

An educational, treatment or living situation within the child's home community that provides appropriate services or programs for a child with disabilities while imposing as few limitations or constraints as possible.

Local Management Entity (LME)

these public entities oversee and manage all public mental health, developmental disability and substance use services through contracts and other arrangements with their local Provider Community (private organizations that deliver direct services). LME's are found within the Managed Care Organizations (MCO's).

Mainstreaming

Placement of a child with a disability in the regular classroom with necessary supports for part of the school day.

Managed Care Organization (MCO)

An organization that combines the functions of health insurance, delivery of care and administration. Local Management Entity (LME's) are located within the MCO's and are a centralized approach to achieving effective management processes. Mental Illness refers to a wide range of mental health conditions or disorders that affect your mood, thinking and behavior.

NC WISE

North Carolina Window of Information on Student Education. This secure web-based tool provides educators with direct and immediate access to a full spectrum of data on a student's entire career in the NC public school system. (permanent record)

Person-Centered-Plan

Individualized and comprehensive family driven/child centered plan that specifies all services and supports to be provided to the individual eligible for mental health and/or developmental disability and/or substance abuse services according to NC Mental Health Reform requirements.

Positive Behavioral Interventions and Supports (PBIS)

A research-based model of school-wide systems of support that include proactive strategies for defining, teaching, and supporting appropriate student behaviors to create positive school environments. Instead of using a patchwork of individual behavioral management plans, a continuum of positive behavior support for all students within a school is implemented in areas including the classroom and non-classroom settings (such as hallways, restrooms).

Related Services

Supports needed to help a child get the most from his special education. Related services are paid for by the public school. They include services such as but not limited to speech, occupational and language therapy, transportation, physical therapy, and mental health counseling.

Strong Able Youth Speaking Out (SAYSO)

A statewide association of youth aged 14-24 who are or have been in the out-of-home care system that is based in North Carolina. This includes all types of substitute care, including foster care, group homes, and mental health placements. Their mission is to work to improve the substitute care system by educating the community, speaking out about needed changes, and providing support to youth who are or have been in substitute care.

School Improvement Plan

A plan that includes strategies for improving student performance, how and when improvements will be implemented, use of state funds, requests for waivers, etc. Plans are in effect for no more than three years.

Service Provider

Any person or agency giving some type of service to children or their families. Part of the Provider Community.

Support Services

Transportation, financial help, support groups, homemaker services, family partner peer support, youth partner peer support, respite services, and other specific services to children and families.

System of Care

Nationally recognized, research-based, best practice framework to build on strengths to meet the multiple and changing needs of children with complex challenges and their families, including a wide range of services and supports organized into a coordinated local network within local communities. A core set of values and principles underlie all planning, implementation and evaluation activities.

Title I

A federal funding program for schools to help students who are behind academically or at risk of falling behind. Funding is based on the number of low-income children in a school, generally those eligible for the free lunch program. Title I money supplements state and district funds.

Title III

The section of No Child Left Behind that provides funding and addresses English language acquisition and standards and accountability requirements for limited English proficient students.

Title IX

Title IX of the Educational Amendments of 1972 bans sex discrimination in schools receiving federal funds, whether it is in academics or athletics.

Title XIX

Medicaid: Medical services funded through Title XIX of the Social Security Act, which matches approximately 54 percent of state funds. Benefits are outlined annually in a Medicaid State Plan and include many different health related services.

Transition

Process of supporting children/youth in the change of services, moving from one program to another, starting or leaving school, or other important life changes. These services should be family driven and youth guided.

Wraparound

Planning, coordination, and delivery of services and supports to children and their families that is individually tailored to each family with the goal of keeping the family together in the community and keeping the child in a regular school setting. In the State of North Carolina best practice utilizes the team process that includes the wraparound coach, facilitator, family support partners and youth support partners. Family Partner Coordinators and System of Care Coordinators provide macro support and light direct services at the MCO level.

504 Plan

A 504 plan is developed to ensure that a child who has a disability identified under the law and is attending an elementary or secondary education institution received accommodations that will ensure their academic success and access to the learning environment. A 504 plan is not an Individualized Education Program (IEP) as is required for Special Education students. However, a student moving from a Special Education to a regular education placement could be placed under a 504 plan.



APPENDIX A

The Evolution of North Carolina's Public Behavioral Health System

The NC Department of Health and Human Services began an overhaul of the state public mental health system in the late 1990s. Specifically on the child/youth side, the Department took service delivery lessons learned from the Willie M. Lawsuit and 26 federal pilot sites in North Carolina to establish key elements in a service systems approach to meet the needs of children with emotional and behavioral challenges and their families – System of Care. This national evidenced based approach expanded state-wide in 2001 through the Comprehensive Services Treatment Program (CTSP) for children at risk of institutionalization or out-of-home placements. By 2003 the State had firmly established SOC approach as the best practice to meet the needs of multi-systems involved children/youth with emotional and behavioral challenges. (The North Carolina Blueprint for Change (DMH/DD/SAS State Mental Health Plan 2003, Chapter 3) and the 2003 DMHDDSDAS Child Mental Health Plan). A 2004 cross-system MoA supporting the following elements was signed at the state and local levels supporting the following key elements:

- Family involvement in decision-making throughout treatment planning and delivery.
- Behavioral health screening for all children at risk of institutionalization or other out-of-home placement.
- A system to ensure that each child/youth received the right amount of the appropriate service at the time the need was first identified.
- Appropriate and medically necessary residential and nonresidential services for special populations of focus including: deaf children, youth with problematic sexual behaviors; children/youth with serious emotional and behavioral challenges and substance use treatment needs.
- Multidisciplinary case management services, as needed.
- Local community collaboratives where families, advocates, community-based providers, local public child-serving agencies and all other child/youth services stakeholders work together to resolve

APPENDIX A

- Outcome-oriented, evidence-based and cost-effective services, including home and/or community-based services.

By 2011, the public mental health system evolved into a statewide Medicaid managed care system. This meant that entities (called LME/MCOs) were given a set amount of funding per year based on the number of Medicaid eligible individuals in their region and charged with the responsibility of contracting with mental health and substance use providers population to provide the behavioral health

services for their region within the set amount of funds that they were given. If these LME/MCOs were able to provide the necessary services to meet the needs of people in their communities and save some of the money, they are able to put the savings back into their regional system to make more services or new kinds of services available to meet additional needs.

There are currently 7 LME/MCOs regions in NC that have been building their managed care systems. DMH/DD/SAS has found the System of Care approach to be a helpful tool:

- highlighting the importance of family members and family partners working together with the LME/MCOs to identify ways to improve child/youth and family access to the services needed.
- helping to provide critical navigation to a complicated system.
- to demonstrate that by identification of special populations of focus for whom to develop wider and deeper service arrays of evidence-based services, communities are able to achieve positive outcomes.
- to demonstrate to LME/MCOs the value of creating a cross-system infrastructure to facilitate communication and efficient use of limited resources.

As the public behavioral health system continues to evolve, the next challenge and opportunity is the integration of behavioral and physical health service delivery systems. By July 2019, the state will be divided into six regions of care. Prepaid Health Plans (PHPs) will be paid lumpsum payments by the Department of Health and Human Services to manage the care of individuals eligible to receive Medicaid and NC Health Choice. There will be two types of PHPs: statewide commercial plans and regional provider-led entities.

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As the public behavioral health system continues to evolve, the next challenge and opportunity is the integration of behavioral and physical health service delivery systems. By July 2019, the state will be divided into six regions of care. Prepaid Health Plans (PHPs) will be paid lumpsum payments by the Department of Health and Human Services to manage the care of individuals eligible to receive Medicaid and NC Health Choice. There will be two types of PHPs: statewide commercial plans and regional provider-led entities. The bulk of those individuals who with basic physical and behavioral health needs will be transitioned to appropriate PHPs by July 2019. Foster care children, the majority of whom are all anticipated to have significant behavioral health needs and will need to be able to access services under complex circumstances are expected to be able to transition to or access a specialty plan by July 2020. However, those with more complex Behavioral health or individuals with more complex behavioral needs and/or intellectual disabilities will not be transitioned into a plan until July 2021 to give more time to develop the specialty framework to best match those needs.



APPENDIX B

System of Care Definition and Philosophy

DEFINITION

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

CORE VALUES

Systems of Care are:

1. Family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided.
2. Community based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level.
3. Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.

GUIDING PRINCIPLES

Systems of Care are designed to:

1. Ensure availability and access to a broad, flexible array of effective, community-based services and supports for children and their families that address their emotional, social, educational, and physical needs, including traditional and nontraditional services as well as natural and informal supports.
2. Provide individualized services in accordance with the unique potentials and needs of each child and family, guided by a strengths-based, wraparound service planning process and an individualized service plan developed in true partnership with the child and family.

¹² Stroul, B., Blau, G., & Friedman, R. (2010). Updating the system of care concept and philosophy. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

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3. Ensure that services and supports include evidence-informed and promising practices, as well as interventions supported by practice-based evidence, to ensure the effectiveness of services and improve outcomes for children and their families.
4. Deliver services and supports within the least restrictive, most normative environments that are clinically appropriate.
5. Ensure that families, other caregivers, and youth are full partners in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for all children and youth in their community, state, territory, tribe, and nation.
6. Ensure that services are integrated at the system level, with linkages between child-serving agencies and programs across administrative and funding boundaries and mechanisms for system-level management, coordination, and integrated care management.
7. Provide care management or similar mechanisms at the practice level to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children and their families can move through the system of services in accordance with their changing needs.
8. Provide developmentally appropriate mental health services and supports that promote optimal social-emotional outcomes for young children and their families in their homes and community settings.
9. Provide developmentally appropriate services and supports to facilitate the transition of youth to adulthood and to the adult service system as needed.
10. Incorporate or link with mental health promotion, prevention, and early identification and intervention in order to improve long-term outcomes, including mechanisms to identify problems at an earlier stage and mental health promotion and prevention activities directed at all children and adolescents.
11. Incorporate continuous accountability and quality improvement mechanisms to track, monitor, and manage the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level.
12. Protect the rights of children and families and promote effective advocacy efforts.
13. Provide services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socio-economic status, geography, language, immigration status, or other characteristics, and ensure that services are sensitive and responsive to these differences.

APPENDIX C

Working Definition of Family Driven Practice

Family-driven means families have the primary role in decisions regarding their children as well as the policies and procedures governing the well-being of all children in their community, state, tribe, territory and nation. This includes, but is not limited to:

- Identifying their strengths, challenges, desired outcomes/goals, and the steps needed to achieve those outcomes/goals;
- Designing, implementing, monitoring, and evaluating services, supports, programs, and systems;
- Choosing supports, services, and providers who are culturally and linguistically responsive and aware;
- Partnering in decision-making at all levels.

Guiding Values to Achieve Family-Driven Practice

Families and youth, providers, administrators, and policymakers accept and support willingly and enthusiastically shared decision-making and responsibility for outcomes, as evidenced by:

1. Families and youth share and have access to accurate, understandable, and complete information necessary to set goals and to make informed decisions.
2. Families define their family composition and family decision-makers, whether biological, adoptive, foster, sibling, or surrogate family voice advocating on their behalf.
3. Families and family-run organizations engage in peer support to reduce isolation, achieve short-and long-term family goals, and strengthen family capacity and voice.
4. Families and family-run organizations provide direction for policy decisions that impact funding, supports, and services, including the right of families and youth to have meaningful voice at the individual and policy level.
5. Providers, agencies, and systems take the initiative to change policy and practice from provider-driven to family-driven.
6. Providers, agencies, and systems embrace family-driven practice, by allocating staff, training, support and resources to adequately fund and sustain family-driven services for children, youth and families, and the work of family and youth run organizations.

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7. Community attitude change efforts focus on removing barriers and eliminating bias and discrimination.
8. Communities value and celebrate the diverse cultures of children, youth, and families and work to eliminate disparities.
9. Communities recognize that culture is an ever-changing dynamic and are responsive to the cultural and linguistic needs of all children, youth, and families.”

APPENDIX D

Youth Guided Practice

Youth Guided means that young people have the right to be empowered, educated, and given a decision-making role in the care of their own lives as well as the policies and procedures governing care for all youth in the community, state and nation. This includes giving young people a sustainable voice and then listening to that voice.

Youth guided organizations create safe environments that enable young people to gain self-sustainability in accordance with the cultures and beliefs with which they identify. Further, a youth guided approach recognizes that there is a continuum of power that should be shared with young people based on their understanding and maturity in a strength-based change process. Youth guided organizations recognize that this process should be fun and worthwhile. (SAMHSA approve 2015)

One of the ways NC offers support for youth guided practice is through Youth M.O.V.E. (motivating others through voices of experience). NC Families United, as the Statewide Chapter of Youth M.O.V.E. will:

1. Promote the involvement of young adults throughout the state by assisting young adults and agency partners with bringing youth leadership development to their area.
2. Offer individual youth memberships to young adults interested in transforming systems (including mental health) while raising awareness and reducing stigma.
3. Improve youth involvement on decision-making boards at the local and state levels.
4. Unite the voices of young adults through youth leadership development and expanding local chapters of Youth M.O.V.E. on North Carolina creating opportunities for peer-to-peer mentoring.

APPENDIX F

LME/MCO Directory/Crisis Line

Alliance Behavioral Healthcare

<http://www.alliancebhc.org/>

4600 Emperor Boulevard

Durham, NC 27703

Phone: 919-651-8400 (tel:919-651-8400)

Fax: 919-651-8672 (tel:919-651-8672)

Crisis Line: 800-510-0132 (tel:800-510-9132)

Counties Served: Cumberland, Durham, Johnston, Wake

Cardinal Innovations Healthcare Solutions

(<http://www.cardinalinnovations.org/>)

550 S. Caldwell Street

Charlotte, NC 28202

Phone: 704-939-7700 (tel:704-939-7700)

Fax: 704-939-7907 (tel:707-939-7907)

Crisis Line: 800-939-5911 (tel:800-939-5911)

Counties Served: Alamance, Cabarrus, Caswell, Chatham, Davidson, Davie, Forsyth, Franklin, Granville, Halifax, Mecklenburg, Orange, Rockingham, Person, Rowan, Stanly, Stokes, Union, Vance, Warren

Eastpointe

(<http://www.eastpointe.net/>)

514 East main Street

Beulaville, NC 28518

Phone: 800-913-6109 (tel:800-913-6109)

Fax: 910-298-7180 (tel:910-298-7180)

Crisis Line: 800-913-6109 (tel:800-913-6109)

Counties Served: Bladen, Columbus, Duplin, Edgecombe, Greene, Lenoir, Robeson, Sampson, Scotland, Wayne, Wilson

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Partners Behavioral Health Management

<http://www.partnersbhm.org/>

901 South New Hope Road

Gastonia, NC 28054

Phone: 704-884-2501 (tel:704-884-2501)

Fax: 704-884-2713 (tel:704-884-2713)

Crisis Line: 888-235-4673 (tel:888-235-4673)

Counties Served: Burke, Catawba, Cleveland, Gaston, Iredell, Lincoln, Surry, Yadkin

Sandhills Center

(<http://www.Sandhillscenter.org/>)

1120 Seven Lakes Drive

West End, NC 27376

Phone: 910-673-9111 (tel:910-673-9111)

Fax: 910-673-6202 (tel:910-673-6201)

Crisis Line: 800-256-2452 (tel:800-256-2452)

Counties Served: Anson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond

Trillium Health Resources

<https://www.trilliumhealthresources.org/>

1708 E. Arlington Blvd.

Greenville, NC 27858-5872

Phone: 866-998-2597 (866-998-2597)

Crisis Line: 877-685-2415 (tel:877-685-2415)

Counties Served: Beaufort, Bertie, Brunswick, Camden, Carteret, Chowan, Craven, Currituck, Dare, Gates, Hertford, Hyde, Jones, Martin, Nash, New Hanover, Northampton, Onslow, Pasquotank, Pender, Perquimans, Pitt, Tyrrell, Washington

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Vaya Health

(<http://www.vayahealth.com/>)

200 Ridgefield Court, Suite 206

Ashville, NC 28801

Phone: 828-225-2785 (tel:828-225-2785)

Fax: 828-225-2796 (tel:828-225-2796)

Crisis Line: 800-849-6127 (tel:800-849-6127)

Counties Served: Alexander, Alleghany, Ashe, Avery, Buncombe, Caldwell, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Watauga, Wilkes, Yancey



APPENDIX G

Tips for Choosing a Service Provider

Source: Vaya Health

As a person seeking services you have the right to choose the provider who will be serving you or your family member. You should always be treated as an individual first rather than a diagnosis or a “label”. It is important to have confidence in your provider in order to form a good working relationship. This relationship is an important support when you or those you care for are facing difficult moments or making decisions which will impact your life. Here are some important questions to ask:

1. What services does your agency provide?
2. What experience does this agency have in working with individuals whose needs are like my own or my family member? (Example: non-verbal, behavior issues, medical problems (tube feeding) etc.)
3. What are the qualifications/credentials required for staff?
4. What in-service orientation and trainings are required-please list?
5. Does staff receive disability specific training?
6. How is staff supervised?
7. May I speak with other families who have received the service I am looking for?
8. Does the family have choice of staff within the agency?
9. Where are services delivered?

Make up your own questions regarding you or your loved ones’ specific support needs.

Also consider the following:

- Choose a time to interview a provider when you feel you are able to communicate clearly.
- Choose an agency staffed by persons who are willing to work with you and be a team player.
- How did the staff member respond to you when you met for the first time?
- Was staff willing to answer your questions?

APPENDIX H

Early and Periodic Screening, Diagnosis, and Treatment

Source: Disability Rights North Carolina

EPSDT is part of the federal Medicaid Act. The Act entitles **children under age 21 who have Medicaid** to all services that are medically necessary to make or keep them physically and mentally healthy. State Medicaid programs must cover any service that is medically necessary to correct or ameliorate a child's physical or mental condition.

A service is **medically necessary** when it corrects or **ameliorates** a condition. A service or treatment ameliorates a condition if it does one or more of the following:

- Improves or maintains the recipient's health in the best condition possible;
- Compensates for a health problem;
- Prevents a health problem from getting worse; or
- Prevents the development of additional health problems.

The State must cover medically necessary services even if those services are not otherwise covered under the State Medicaid Plan.

EPSDT services includes both short-term and long-term services. It also includes durable medical equipment, prosthetics, wheelchairs, oxygen equipment, communication aides, and other equipment—as long as they are medically necessary.

Under the federal Medicaid law, there are mandatory services, which states must provide to Medicaid recipients, and optional services, which states may provide. EPSDT requires that the State Medicaid program provide all **mandatory and optional services** to children who have Medicaid, if those services are medically necessary.

There is no set list that specifies what EPSDT services or equipment are covered. However, a service will only be covered if it falls within the scope of those services listed in the Medicaid Act. For example, neither autism services (such as applied behavioral analysis) nor equine therapy is listed in the Act. However, both can be covered under EPSDT because they fall within the scope of at least one of the services listed in the Act.

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Here is the list of services found in the Medicaid Act:

- Inpatient and outpatient hospital services
- Physician services
- Clinic and rural health clinic services
- Health center services
- Laboratory and x-ray services
- Family planning services and supplies
- Dental services, medical/surgical services from a dentist, and dentures
- Home health care services
- Private-duty nursing
- Physical and occupational therapy
- Services for speech, language, and hearing disorders
- Prescribed drugs
- Prosthetic devices
- Eyeglasses
- Intermediate care facility services
- Medical and remedial care
- Diagnostic, screening, preventive, and rehabilitative services
- Inpatient psychiatric hospital services
- Midwife services
- Hospice care
- Case management
- TB-related services
- Respiratory care
- Pediatric or family nurse practitioner services
- Personal care service

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EPSDT also requires the State to cover transportation to or from medical appointments. It even covers out-of-state travel, lodging, and meals, if the travel is medically necessary. Contact your local Department of Social Services to arrange for reimbursement before you travel.

EPSDT is limited to **rehabilitative services** and does not include habilitative services. In general, rehabilitative services involve re-teaching a skill that has been lost, while habilitative services involve teaching new skills. However, the distinction between the two types of services is often blurred, and a service that is habilitative in one instance may be considered rehabilitative in another.

For details, read North Carolina's EPSDT Policy Instructions Update, available at

<https://www2.ncdhhs.gov/dma/epsdt/epsdtpolicyinstructions.pdf>.

Limits do not apply: North Carolina's Clinical Coverage Policies explain the limits on scope, amount, duration, frequency, location of service, and other specific criteria for all covered services. However, under EPSDT, these limits may be exceeded or may not apply at all. Your child can receive more hours or visits of the requested service than are allowed under the Clinical Coverage Policies if it is medically necessary.

Other restrictions that do not apply under EPSDT include the location of the service (for example, the Policies say Personal Care Services should only happen in the home) and prohibitions on receiving multiple services on the same day or at the same time. The provider of the service should document how the service, product, or procedure meets all EPSDT criteria and why it is medically necessary to exceed the limits outlined in the Clinical Coverage Policies.

You can find all of North Carolina's Clinical Coverage Policies at

<https://dma.ncdhhs.gov/providers/clinical-coverage-policies>.

Screenings and Diagnostic Services under EPSDT

Screenings and Diagnostic Services under EPSDT: A good example of a screening service is a child's regular check-up with a pediatrician. EPSDT requires that Medicaid cover screenings for physical health, dental health, vision, and hearing. Medicaid must also cover periodic developmental and behavioral screenings in order to identify any intellectual or developmental delay or disability.

If any screening identifies a possible health issue or disability, the state must provide whatever services or assessments are necessary to diagnose the condition.

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Treatment under EPSDT: The State must provide medically necessary treatment for a child who has Medicaid and has been diagnosed with a health condition or a physical or mental disability. **Even if the condition existed before the child started to receive Medicaid, it must be covered.**

In addition to being medically necessary, EPSDT policy requires that a service or treatment meet the following criteria:

- It is medical in nature.
- It is safe and effective.
- It is generally recognized as accepted medical practice or treatment.
- It is not experimental or investigational.

There is no co-payment or other cost to the recipient for services covered by EPSDT. Also, there is no waiting list for EPSDT services. However, doctors or other practitioners may have waiting lists to schedule appointments or procedures.

Requesting Services: You do not need to say you are requesting EPSDT services. However, if you have trouble getting your provider to prescribe a needed service for your child, or if Medicaid refuses to pay for the service, citing EPSDT policies may help you make your case to receive services.

The recipient's physician, therapist, or clinician must request the service and be able to show that the service is medically necessary. Documentation showing the medical need for the service is the most compelling evidence you can have to convince Medicaid to cover the service. The courts have held that states should give deference to the medical opinions of treating physicians and therapists.

Waiver Programs and EPSDT: North Carolina has three Medicaid waiver programs—the Innovations Waiver for people with intellectual and developmental disabilities, CAP-C for children with complex medical needs, and CAP-DA for people age 18 and older with significant medical needs. Even if your child receives services through a waiver, he or she is also eligible for EPSDT services.

APPENDIX H

The Importance of Case Management: You might not think of Case Management as a medical service. However, for many families, Case Management is medically necessary to connect children to appropriate services and supports. Case Managers advocate for recipients and help families navigate the complex systems of services for mental health, substance abuse and intellectual/developmental disabilities. They may also interact with schools and the juvenile justice system on the recipient's behalf.

You should ask for Case Management if you feel that your child is "slipping through the cracks" and you need help making sure your child gets the services he or she needs.

APPENDIX I

North Carolina Treatment Program

<https://ncchildtreatmentprogram.org/>

1-844-622-8748

The North Carolina Child Treatment Program trains approximately 250 clinicians per year in one of the following evidence-based treatment (EBT) models.

- Attachment and Biobehavioral Catch-up (ABC) –Focuses on children who have experienced early adversity/maltreatment (e.g. separation from caregiver, neglect) Note: NC CTP does not train on this model. ABC parent coaches are trained through the University of Delaware.
- Child-Parent Psychotherapy (CPP) – children ages 0-5 years; trauma-focused. For children who have been through a traumatic event and are experiencing behavioral and/or emotional problems. Focuses on the relationship between the child and caregiver and uses that relationship to help the child feel safe again.
- Parent-Child Interaction Therapy (PCIT) – Children ages 2-6 years; trauma-focused; Provides highly-specific, step-by-step, live coached sessions with both the caregiver and the child. Caregivers are coached in specific skills as they interact in guided play with the child.
- Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) -- Adolescents ages 12-18 years; trauma-focused; Addresses the needs of chronically traumatized adolescents who may still be living with ongoing stress and are experiencing problems in several areas of functioning.
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Children ages 3-21 years; trauma-focused. For children who have experienced a traumatic event and are experiencing behavioral and/or emotional difficulties as a result. Children and caregivers work together to develop new skills to process the traumatic event and resolve behavioral/emotional difficulties.

Clinicians participate in a rigorous learning collaborative training process and work with CTP master trainers and consultants to become proficient in a specific treatment model. After successfully completing the process, they are included in the NC CTP roster of clinicians.

See information on trauma and attachment issues:

https://ncchildtreatmentprogram.org/caregiver_kids.php

Source: <https://ncchildtreatmentprogram.org/> 10-04-2017

APPENDIX J

From SAMHSA 2013 bulletin pg. 6

Trauma-Informed Systems and Evidence-Based Treatments Addressing Trauma

Across the country, including system of care sites and the PRTF demonstration states, there is an increased awareness of the impact of trauma. Children and youth with the most challenging mental health needs often have experienced significant trauma in their lives. The Adverse Childhood Experiences (ACE) study has reported short and long-term outcomes of childhood exposure to certain adverse experiences that include a multitude of mental health, health and social problems. More information on the ACE study can be found at: <http://www.cdc.gov/ace/findings.htm>

To begin addressing the trauma needs, many states are providing training and coaching for their clinicians in evidence-based practices such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Parent-Child Interaction Therapy (PCIT). Many states are also exploring new policies and practices to ensure that they have trauma-informed systems of care that will be less likely to re-traumatize the children and youth they serve.

Additional resources related to trauma can be found on the National Child Traumatic Stress Network website at: <http://www.nctsn.org/>

APPENDIX K

What Families Say They Want

Before the meeting:

- Give me a chance to share my story
- Help me to find my informal supports so that they can come to the meeting
- Educate yourself about my child's illnesses or my situation, don't just say you don't know
- Listen to my needs and my family's needs
- No surprises-make sure I know beforehand what we will be talking about at my meeting
- Don't have the meeting unless I can come if it is about me
- Work with me to set up a time that I can be present at the meeting and be sensitive to my needs
- Recognize my feelings as a parent i.e. Angry, scared and tired of the mess
- Help me understand how the meeting works and what are my options
- Listen to what I am saying and explore why I am saying it

At the meeting:

- Allow me to introduce myself to the team
- Talk to me, not about me
- Monitor your tone of voice
- Call me by my name not "mom", "dad" or "the youth"
- Make sure I have someone at the table I feel will support me
- Use words I can understand
- Use humor to make me feel safe
- Give me a chance to share my story
- Help me to meet my immediate needs first like housing, transportation, childcare, food, lights
- Remind me of my family's strengths and build on them
- Ask me how my situation looks in my child and family's life...How it impacts us
- Provide services where needed not just mandated services. Don't waste my time on services that will not help my family

APPENDIX K

- Know what the family has to do in all of the agency plans so we can come up with one plan
- Listen to my needs and my family's needs
- Use visual prompts so I can follow better
- Tell the truth
- No surprises-make sure I know beforehand what we will be talking about at my meeting
- Let me explain why I behave the way I do
- Let us speak more
- Be open to questions and our opinions
- Make the meeting more active and fun
- Everyone comes like they said they would
- Speak to the me and my child like we are a part of the solution not like we are the problem
- Ask for information; don't assume you know the answers
- Provide access to resources and services
- Respect me, and that I am doing what I know to do

After the Meeting:

- Respect my confidentiality-don't talk about me to others
- Allow me the opportunity to call meetings when I feel I need to
- All team members need to be held accountable, not just the parents

APPENDIX L

DHHS Crisis Services Webpage

<https://www.ncdhhs.gov/assistance/mental-health-substance-abuse/crisis-services>

Find help for a mental health or substance use crisis in your county

Anyone may request crisis or emergency services in North Carolina for mental health, substance abuse, intellectual and developmental disabilities issues.

- Find help for a mental health and substance use crisis in your county
- If this is a medical or a life-threatening emergency please call 911
- If you need to contact the police, request a Crisis Intervention Team officer

Behavioral Health Urgent Care

Behavioral Health Urgent Care sites provide immediate care to adults, adolescents or families in crisis.

Care may include:

- Assessment and diagnosis for mental illness, substance abuse and intellectual and developmental disability issues
- Planning and referral for future treatment
- Medication management
- Outpatient treatment
- Short-term follow-up care

Until the consumer is established with a local clinical provider, they may return to the community from a state psychiatric hospital or alcohol and drug abuse treatment center.

Crisis Solutions Coalition

The Crisis Solutions Coalition is comprised of client advocates, along with leaders from healthcare, government, law enforcement and magistrates, schools, healthcare providers, paramedics, emergency departments, community health centers and others. They focus on identifying and implementing best known strategies for crisis care while reducing avoidable visits to emergency departments and involvement with the criminal justice system. This includes:

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- Recommending and establishing community partnerships to strengthen the continuum of care for mental health and substance abuse services.
- Promoting education and awareness of alternative community resources to the use of emergency departments.
- Making recommendations related to data sharing to help identify who, when and where people in crisis are served, and what the results of those services are.
- Creating a repository of evidence-based practices and providing technical assistance to Local Management Entities-Managed Care Organizations (LME/MCOs), law enforcement and providers on how to respond to crisis scenarios.
- Recommending legislative, policy and funding changes to help break down barriers associated with accessing care.

The Crisis Solutions Coalition meetings are public. To receive occasional informational emails and notices of the meetings, contact us at crisissolutionsnc@dhhs.nc.gov. Please note: This email box is not monitored on a 24/7 basis and is not for emergency situations. For resources to assist you with a crisis immediately, select your county from the drop-down box on [Crisis Solutions NC](#).

Coalition Documents

Mobile Crisis Teams – check your local LME/MCO for availability in your area

Mobile Crisis Management services are available full time for crisis prevention or if you or someone you know is experiencing a crisis related to mental health, substance abuse or developmental disabilities. Mobile Crisis teams can meet you in a safe location, including your home, school or workplace.

Professional Treatment Services in Facility-Based Crisis Program

This service provides an alternative to hospitalization for adults in crisis who have a mental illness, substance abuse disorder or intellectual/developmental disability. Services are provided in a full time residential facility.

Services include:

- Short-term intensive evaluation
- Treatment intervention
- Behavioral management

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Before contacting your local facility-based crisis provider, contact your current mental health, substance abuse or developmental disabilities service provider or your local management entity's access and crisis line.

Facility-Based Crisis Programs

Monarch opened its Facility-Based Crisis (FBC) center for children and adolescents located at 1810 Back Creek Dr. in Charlotte, January 2018.

The facility is the first of its kind for youth and teens in North Carolina who experience a mental health and substance use crisis and need 24/7 triage, assessment and stabilization in a secure, nurturing in-patient setting. Call (844) 263-0050 for more information, or visit www.MonarchNC.org

The North Carolina Behavioral Health Crisis Referral System (BH-CRSys)

is a secure web-based system available to professionals serving individuals experiencing behavioral health crisis. Users can search for availability at appropriate placement facilities and send select referral/screening information to the potential receiving facility.

From North Carolina's Mental Health Crisis Fact Sheet: <http://crisissolutionsnc.org/wp-content/uploads/2014/01/CSIfactsheet12-27-13.pdf>

- On average, 150,000 patients with a primary diagnosis of a behavioral health condition (mental health, developmental disability or substance use disorder) are seen in Emergency Departments (EDs) across NC each year. In 2015, approximately 30% of these patients were referred for inpatient care. *
- In 2017, the average wait time for referrals to a state hospital for a person in the ED was more than
- 120 hrs. (5 days). *
- EDs are only one of many types of facilities that serve individuals in crisis that are seeking to place individuals in a higher level of care.

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Child inpatient beds are limited. North Carolina has sought to include crisis resources for children and youth in order to decrease the demand. DMH/DD/SAS has worked with other agencies to create a system that allows emergency department staff and those who are facilitating a child or youth's transfer to acute inpatient care, to know which beds are available where instantly.

By providing a single location for information, a streamlined process and mechanism to identify needs, BH-CRSys has the potential for impact at every level, from the individual seeking treatment to identifying the services needed statewide.

The goals of BH-CRSys program include:

1. Reducing the length of time behavioral health crisis patients wait to be placed in an appropriate treatment facility.
2. Increasing the efficiency and timeliness of a psychiatric inpatient bed acceptance process for both referring and receiving facilities.
3. Potentially reducing the distance an individual/family must travel for inpatient treatment.
4. Collecting information to help inform the crisis system and meet the needs of the person served.

For more information, contact bhcrys@dhhs.nc.gov



NORTH CAROLINA
System of Care

