

# 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.”*

# TABLE OF CONTENTS

<b>System of Care</b> .....	<b>pg 6</b>
What the System of Care is	
How families are involved in the System of Care	
<b>Mental Health Care</b> .....	<b>pg 17</b>
Benefits of mental health services	
North Carolina's Mental Health Reform	
Kinds of mental health services	
<b>Child and Family Teams (CFTs)</b> .....	<b>pg 26</b>
What Child and Family Teams are	
What Child and Family Teams do	
How Child and Family Teams work	
<b>Child and Family Plans</b> .....	<b>pg 29</b>
The purpose of Child and Family Plans	
How Child and Family Plans are developed	
Crisis Plans	
<b>Child and Family Team Meetings</b> .....	<b>Pg 34</b>
The steps of a Child and Family Team Meeting	
How to get ready for Child and Family Teams	
<b>Family &amp; Team Strengths</b> .....	<b>Pg 40</b>
How to discover your family's strengths	
How information about family strengths is used in planning	
Team Strengths in your Child and Family Team	
<b>Advocacy &amp; Communication</b> .....	<b>Pg 45</b>
How to become an effective advocate	
Getting your message across to others	
<b>Writing Letters</b> .....	<b>Pg 49</b>
Why writing letters is helpful	
Sample letters	
<b>The System of Care in North Carolina</b> .....	<b>Pg 55</b>
A description of how child serving systems	
are adopting System of Care approaches	
<b>Acronyms &amp; Terms</b> .....	<b>Pg 59</b>
<b>Trauma Information for Families</b> .....	<b>Pg 75</b>



# WELCOME

The goal of System of Care is to help families help their children succeed at home, in school and in the community. In North Carolina and nation-wide, System of Care is considered the best way of planning, developing and delivering services to children and their families. Because children are not little adults, their services must be planned and delivered in ways that fully involve their families, peer groups, neighborhoods, schools and community. This is especially important for children who have serious challenges related to their behaviors, health, school performance and safety at home, in their schools, and in the community. System of Care is fundamentally changing the relationships families have to the service system at every level. Collaboration and partnership between families and service providers is the thread that links successful programs, policies and practices. Many federal and state policies mandate parent involvement. Parents now provide services, act as advocates for change, mentor other families, shape programs, create policies and carry out public service agendas. Parents and professionals working collaboratively as partners are now recognized as a best practice. These collaborative partnerships have resulted in measurable and direct positive benefits for families, children and providers.<sup>1</sup>



More than 200,000 children under the age of 18 in North Carolina have a serious emotional disturbance. 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. A recent North Carolina study reported that caring for children with emotional disorders takes a toll on the child's family, causing harm to the family's well being. The effects tend to worsen over time, suggesting that the families and caregivers do not get used to caring for their children.<sup>2</sup> Our current systems are often ill equipped to deal with the multiple and varied challenges and needs of these children and their families. Feelings of isolation, frustration and anger are the norm as families attempt to find help for their children and support for themselves.

North Carolina's mental health system continues to undergo reform and reorganization to serve families and children more effectively through a System of Care approach. This approach, with family partnership at its core, has been successfully piloted in at least 23 North Carolina counties. The resulting outcomes led to the adoption of the System of Care approach as a key reform element in the State's mental health reorganization plan. The North Carolina "Blueprint for Change" (Division of MH, DD, SAS State Mental Health Plan 2003, Chapter 3) and the 2003 "Child Mental Health Plan" (DMH, DD, SAS) have identified the following as core requirements and /or values for the future provision of children's mental health services.

- ◆ Families will have meaningful input in all aspects of the planning, delivery and evaluation of services.
- ◆ Families and professionals working together maximize the benefits of the services rendered.
- ◆ Utilize "best practice" models that include family support, family education and family training.
- ◆ Create support systems to ensure family participation.

This approach serves the whole family, respects the family's strengths, their knowledge about their children, and does not restrict children and families to a 'one size fits all' routine. However, System of Care is not just about 'mental health'; it promotes good mental health, but also looks with families across the areas of their lives to determine how to help their children succeed in a variety of ways. System of Care assists the community of helping professionals to take the burden of service coordination 'off the backs of families'<sup>3</sup> and to better support children and their families through team work in services, in community planning, and in the development of effective new rules and policies in state and local government. (See page 54 for a description of how North Carolina's juvenile justice, education and social service systems are implementing reforms consistent with System of Care.)

As we develop System of Care in communities across North Carolina, we are discovering that we very much need the help of parents and youth to help create strong and lasting positive changes in our child-serving systems. Changing the 'way business is done' means that families, youth, professionals and the community work as full partners to help make sure that children and families have the support and services they need, when and where they need them.

System of Care is based on a set of values and principles for local services and supports in communities across our State. Those principles and values set a high standard for how services and supports are developed and delivered. At the same time, System of Care is not 'just' a philosophy; it is a research-based framework<sup>4</sup> that helps communities and states put the philosophy into action by building structures and resources that make System of Care work for children and their families. System of Care looks a little different in each community because it is based on the strengths and needs of the families in those communities. **This handbook provides basic information about the System of Care approach and its framework to help children, youth and their families know what to expect and how to get involved in building the strongest System of Care possible in their particular community.**

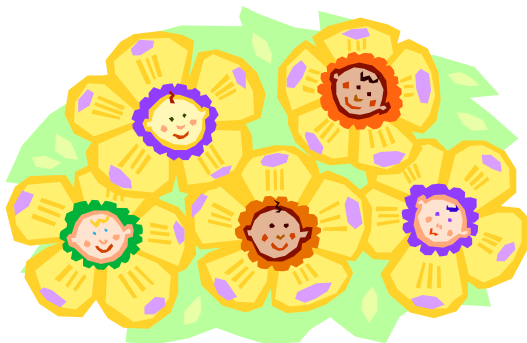
## Acknowledgements

The contents of this handbook are based on the work of families and professional partners. A first version was developed as part of a System of Care grant process in North Carolina. As North Carolina continues to build on what it learns from families, professional and community partners about how to make a System of Care really work to help families help their children, this handbook will continue to be revised to reflect current changes and progress. North Carolina Families United, Inc. is now taking the lead in revising this new version of the SOC Family Handbook, in partnership with the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services and other child-serving systems through the North Carolina State Collaborative for Children and Families. This version of the handbook describes System of Care, key aspects of Mental Health Reform, and how other child-serving systems are implementing reforms consistent with System of Care.

NC Families United, Inc. is a statewide organization for parents, families, and caregivers of children with mental health, emotional, and behavior health challenges and professionals that share our mission. It is also North Carolina's statewide Federation of Families for Children's Mental Health organization, affiliated with the national Federation. We believe that most children can and should be served in their homes with the proper supports and interventions in place. We also believe in prevention, early intervention, and community-based services for children and families that promote safety, permanence, and wellness in the home, school, and community. We hope that parents who use this handbook find it to be a helpful tool to support them as full partners in the System of Care.

For more information about North Carolina Families United, Inc., contact Patricia Solomon NC Families United Coordinator, at 704-892-1321 or 910-331-6092 by phone, email: <mailto:phsolomon@earthlink.net>, or by mail, at 907 Barra Row, Suites 102/103 Davidson, NC 28036.

For information about Cumberland County's System of Care, Contact Robin Jenkins, at 910-222-6089 or call the Mental Health Center and ask for Debbie Jenkins at 910-222-6354.



# SYSTEM OF CARE

## *What is a System of Care (SOC)?*

The purpose of a System of Care is to make comprehensive, flexible and effective support available for children, youth and families throughout the community and through this assistance make the community a better place to live (Franz, John).



The Child, Adolescent and Family Branch of the Center for Mental Health Services and the Steering Committee of the Council for Coordination and Collaboration for the Comprehensive Community Mental Health Services for Children and Their Families Program have published their official definitions of a System of Care from a 'mental health' perspective:

The short definition says that a system of care is a network of community services and supports for children and youth with serious mental health needs. Families, youth and providers become partners so each child can function better at home, in school, and in the community. The longer definition says that a system of care is a coordinated network of community-based services and supports that are organized to meet the challenges of children and youth with serious mental health needs and their families. Families and youth work in partnership with public and private organizations so services and supports are effective, build on the strengths of individuals, and address each person's cultural and linguistic needs. A system of care helps children, youth and families function better at home, in school, in the community and throughout life.

In a broader view, System of Care is an organized network of services and supports that helps children with complex behavioral, education, social, and/or safety needs and their families get the services they want and need in their local communities. A key focus of this Handbook is on mental health issues. *However, System of Care is not just used to meet mental health needs and it is not a mental health 'program'.* A System of Care integrates the work of education, juvenile justice, health, mental health, child welfare, family court, and other helping organizations with families through team work and shared responsibility. Families are seen as important team members, working side by side with professionals and community members to plan, deliver, and monitor services for their children.

System of Care is a way of 'doing business' among professionals, families and the community. A System of Care is beneficial to families and communities because it increases community services and resources, reduces unnecessary separation of children from their families, and actively supports the development of healthy and productive families. System of Care is supported by research and the accepted national 'best practice model' for delivering services and supports to children with complex needs and their families in a way that they can understand and starting where they are.

North Carolina's State Legislature just passed new requirements that promote System of Care approaches in service delivery for children and their families. They created a Study Commission that will look at whether and how to require System of Care as the overall way that services to children and families are delivered in all child serving systems in the future.

### *How does a System of Care work?*

In a System of Care, every effort is made to build on the personal strengths of each child and family, and community. Resources available to children and families through their extended family, neighborhoods and the broader community are recognized as important and enduring sources of family support. At the same time, 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. System of Care is clearly based on a strong set of values and principles. However, it is not 'just' a philosophy. It is a well-defined model that helps children, youth, families, providers and community work together to help families help their children succeed in home, school, and in the community. This is done through a teamwork approach:

- 1) Child and Family Teams** provide direct services and supports: Children with complex challenges and needs, and their families, often need a flexible mixture of formal agency services and informal supports (such as recreational clubs, mentoring by a family friend) in order to reach their goals. In a System of Care, these supports and services are planned, coordinated, delivered and monitored through a Child and Family Team. The Child and Family Team (CFT) is the 'heart' of the System of Care, building a team unique for each family, comprised of those persons who are important in their everyday lives.

In North Carolina, Child and Family Teams are the way that children and their families get the help and assistance they need to plan their services, have them delivered in a coordinated way, and constantly assess what's working and what's not working - changing the plan as needed to better meet the needs of the child and family over time. Many of the 'child-serving systems' (such as social services, juvenile courts, mental health, etc.)

are beginning to require Child and Family Teams as the way they plan and deliver services, which is consistent with national 'best practices'. For example, children and families who need behavioral health services can receive a Person/Family Centered Plan in accordance with NC Mental Health Reform. This is available for those children who: 1) receive behavioral health services through the Local Management Entity (formerly known as Area Mental Health, Developmental Disability, and Substance Abuse Authorities) and 2) qualify for Enhanced Benefits (the most comprehensive services available from the mental health system) because they meet eligibility for a Target Population (those who have the most severe challenges). Other human service systems in North Carolina use Child and Family Teams to plan and deliver many services as well, such as local Departments of Social Services, local Treatment Courts, etc.

- 2) **Community Collaboratives** promote teamwork and change in the broader community that is necessary for Child and Family Teams to succeed in their work with children and families. A Community Collaborative is a diverse governance team that brings together decision-makers (people responsible for services) and stakeholders (people using the services) to "drive", manage, and monitor the local System of Care. It requires that providers work together with families and communities in a give-and-take way - finding and building common goals, finding concrete ways to promote collaboration, put into practice best practices and decrease fragmentation instead of protecting turf and business as usual. Members of Child and Family Teams should bring concerns and needs to their Community Collaborative. For example, help in developing new services to fill service gaps identified through Child and Family Teams, help to organize System of Care trainings, and other activities that help Child and Family Teams help children and families succeed in their local community. In order for Child and Family Teams to succeed, community leaders and local organization decision-makers must also work together as a team.
- 3) **The State Collaborative** is a state level group of administrators, families, advocacy organizations, educators, private providers and public providers that work together in a neutral environment to identify strengths, issues, barriers, funding, and identify policy and legislative mandates that need to be addressed in order to develop a seamless System of Care for children and families in North Carolina. The State Collaborative supports 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

### ***What is the role of families in a System of Care?***



Families are at the center of the System of Care. They should expect to be partners in the local Community Collaborative with agencies, schools, and others in the Community. They should also expect to have a strong voice on their Child and Family Team, planning and making decisions about their child's services and supports. Families inform Child and Family Team members about their strengths and values, and they advocate for their children and themselves. Families help inform Community Collaboratives about what services and supports are needed in their community in order to help children and families succeed.

### ***How is this approach different?***

Two of the key ways System of Care is different from conventional service delivery approaches are the amount of family involvement and the focus on family strengths; it is a 'child focused family-centered' model. First, System of Care uses the personal strengths of the family and other team members to plan and deliver services. Second, it involves families as partners on teams that plan services and make decisions about services for their own children and to help improve services for other children and families in their community. System of Care is based on a set of values, principles and beliefs about how children and their families should expect to receive services and be involved in improving things for their own and other families in the community:

- ◆ There is a comprehensive array (types) of local services & supports
- ◆ Services and supports are individualized according to the child and families' unique strengths, challenges, and needs
- ◆ Services and supports are provided in the least restrictive, most normative environments that promotes recovery and connection to family and friends
- ◆ Families and surrogate families are full participants in all aspects of the System of Care
- ◆ Services and supports are included and connected in the plan
- ◆ Case management services help families organize and work with in multiple services
- ◆ Children and their families' strengths, challenges, and needs are identified and addressed early
- ◆ Youth receive help to transition to adult services
- ◆ Children and their families receive effective advocacy to protect their rights
- ◆ Services and supports build upon child and family strengths and are responsive to cultural differences and special needs

There are several key outcomes, or results, for children, families and the community that should be expected from active implementation of System of Care. These include:

- ◆ Increased school attendance and children finishing school
- ◆ Safer schools
- ◆ Decreases in home, school, and community violence

- ◆ Decreases in out of home placement
- ◆ Decreases in abuse and neglect
- ◆ Decreases in juvenile arrests
- ◆ Creation of a child and family friendly System of Care
- ◆ Increased power of advocacy for children and family issues in the political system at the state and local level
- ◆ Stronger children, youth, families and communities

It takes time to implement System of Care and to see improvements. One way to get a sense of how System of Care is different and whether improvements are occurring is to contrast System of Care with more 'conventional' approaches to providing services to children and their families, as illustrated below:

'Conventional' Approach to Care	System of Care
<ul style="list-style-type: none"> <li>◆ Plans are service-driven</li> <li>◆ Children's needs are matched to a menu of existing services</li> <li>◆ Plans are child-centered</li> <li>◆ Service plans are developed FOR (not necessarily with) children</li> <li>◆ Plans list strengths but focus on deficits</li> <li>◆ Services are often offered as a "one size fits all"</li> </ul>	<ul style="list-style-type: none"> <li>◆ Plans are driven by the strengths and needs of the child and family</li> <li>◆ Plans incorporate existing services if family needs them, but rely heavily on newly created services, informal supports and community resources</li> <li>◆ Plans are family-driven and child-directed</li> <li>◆ No planning sessions occur without presence of family and youth (if appropriate for the youth)</li> <li>◆ Plans are strength based and use unique strengths, values, attitudes and preferences of child, family and community</li> <li>◆ Services are culturally competent and individualized</li> </ul>

Every community is a little different in their progress in implementing a System of Care and how they include families. For another helpful tool to assess where your community is in this development, see the table on page 13 of this Handbook.

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

There are many benefits and opportunities for families when they become actively involved in the System of Care. Some of the benefits are listed below<sup>5</sup>:

- ◆ Provides opportunity to effect meaningful change
- ◆ Feels good to make a contribution
- ◆ Increase confidence in ability to effect change
- ◆ Makes providers accountable to families
- ◆ Provides opportunities to network with other families and providers
- ◆ Builds knowledge and skills
- ◆ Models community involvement and empowerment for own children and family
- ◆ Creates less passive recipients of care and services
- ◆ Makes things better for other families
- ◆ Opens doors to employment
- ◆ Creates a sense of belonging
- ◆ Offers a sense of accomplishment
- ◆ Increases sense of person power
- ◆ Offers leadership role models for other families
- ◆ 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 in helping professions as well as the entire community. Some of the ways that helping professionals and communities benefits from family involvement are listed below<sup>6</sup>:

- ◆ Improves quality of programs and services
- ◆ Increases responsiveness of programs and policies
- ◆ Keeps programs relevant and realistic
- ◆ Brings fresh perspectives, creative solutions, limitless creativity
- ◆ Increases visibility of and respect for program in community
- ◆ Increases cohesiveness and collaboration between agencies
- ◆ Helps save \$\$ reduces waste
- ◆ Improves ability to accomplish mission
- ◆ Develops a constituency that can advocate for program/agency
- ◆ Increases appreciation of various culturesContributes to the stability of the community

## ***How can I be successful as a partner in planning my child's care?***

Professionals everywhere are realizing more and more that parents are the real experts when it comes to their children. As you work with mental health professionals, community members, school staff, and others, you will become aware of the strengths and knowledge you bring to the team. Here are some thoughts to keep in mind.

- ◆ You have important information about your child that no one else has because you know your child the best.
- ◆ One of your jobs is to let others know about your child's strengths and interests, and what your child needs. You can ask questions and get help whenever you want it to help you do your job on your Child and Family Team.
- ◆ You are part of a team that works together to solve problems and develop a plan.

## ***What services and supports do families get in a System of Care?***

Services in a System of Care should be different for each family because they are built on the unique strengths and needs of each family. The goal is to make sure those children with behavioral, education and/or safety needs and their families get the specific services and supports they want and need. In a System of Care, families should expect that service providers first want to learn about the unique strengths, interests and culture of your family so they can help you build on those strengths to identify services and supports that meet your needs.

Some things that families should expect to be asked by professional partners in a System of Care are<sup>7</sup>:

- ◆ What you like most about your children (looking for parent preferences and differences)?
- ◆ What are your goals- what would life look like if things were better?
- ◆ What are your goals for your children?
- ◆ What you see as your and your children's biggest accomplishments?
- ◆ What makes you and your children happy?
- ◆ What are your favorite memories of your family?
- ◆ How you see yourself as a parent - what you see as your best qualities?
- ◆ What special rules you have in your family?
- ◆ Who are your and your children's friends, who you call when you need help or want to talk, and who you consider to be supportive?
- ◆ How your family has fun, what you prefer to do?
- ◆ What are your family's traditions or cultural events that 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?

Once service providers know more about your families' particular goals, strengths and preferences, you should expect them to help you identify what you need to achieve those goals. Then you can begin to identify the individuals who can help you achieve these goals by providing services or supports, and invite them to participate on your Child and Family Team. Your case manager or Child and Family Team facilitator should then help organize your Child and Family Team meeting to begin planning and delivering those services and supports.

### ***Who is in charge of a System of Care?***

Many agencies and community helpers work together to form a System of Care. No single agency is in charge. You and your Child and Family Team make the major decisions about your child's plan and how it is carried out, so in many ways you are in charge. There may be a time when a needed service is not available in your area. You may need to compromise, and a creative way of filling the need may have to be developed. The Community Collaboratives should work together to listen carefully to the needs of Child and Family Teams and help develop a strong local System of Care to better meet those needs.

The national Federation of Families for Children's Mental Health is developing a working definition of what we mean by Family Involvement to help describe the lead role that families should expect to take, especially as it relates to their children's mental health challenges and needs. According to this definition:

Family-driven means families have a primary decision making role in the care of their own children as well as the policies and procedure governing care for all children in their community, state, tribe, territory and nation. This includes:

- Choosing supports, services and providers;
- Setting goals;
- Designing and implementing programs;
- Monitoring outcomes and
- Determining the effectiveness of all efforts to promote the mental health and well being of children and youth.

### ***How can I find out more about the System of Care?***

If you want to learn more about the System of Care contact:

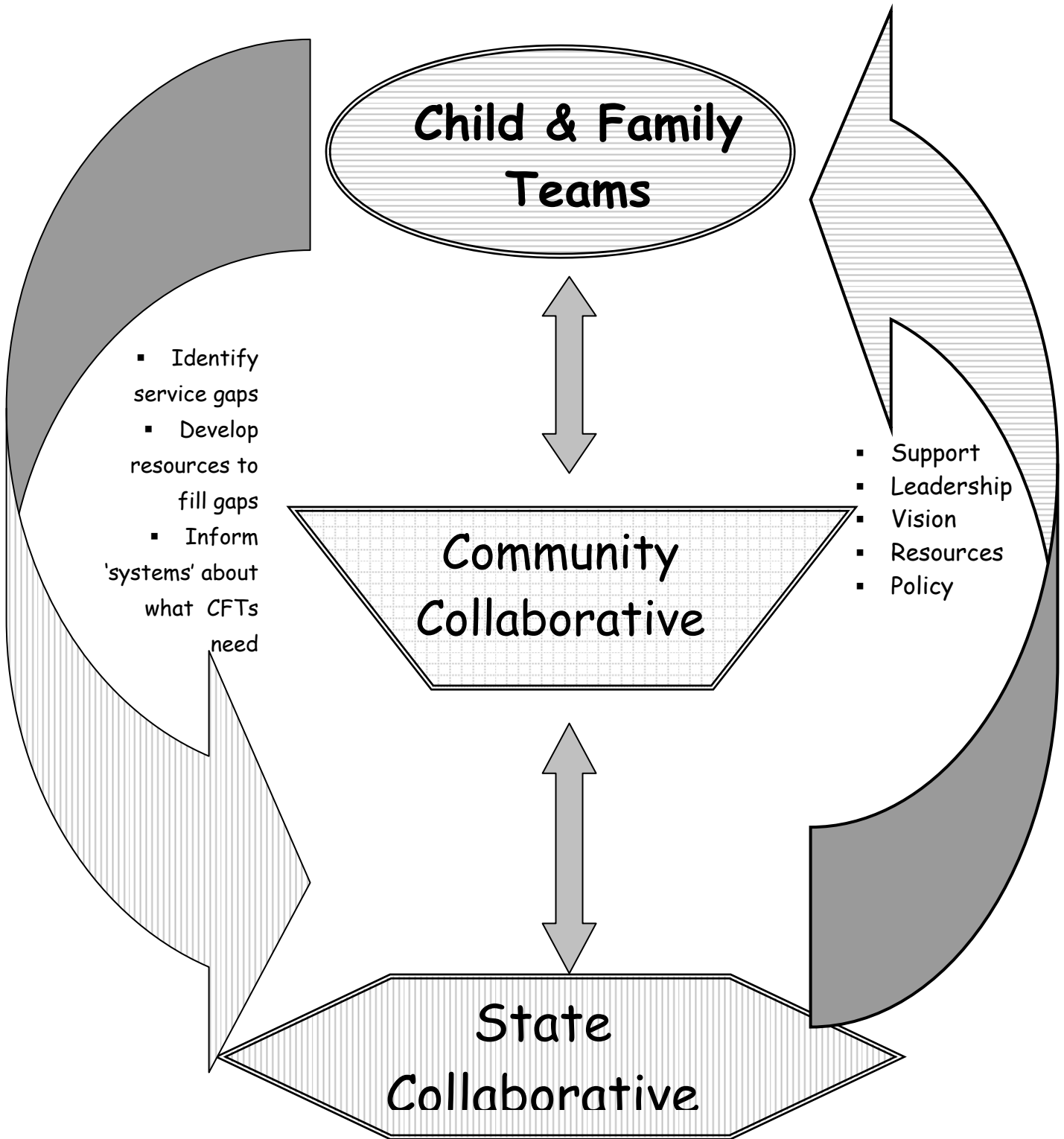
- ♦ NC Families United, Federation of Families for Children's Mental Health - Pat Solomon, NC Families United Coordinator, 704-892-1321 or 910-331-6092.



- ◆ Your local Community Collaborative (contact your Local Management Entity, who is responsible for staffing the local Collaborative)
- ◆ Local family organizations (See list at the end of the handbook)



# STRUCTURE OF NC SYSTEM OF CARE



## *Stages of Family Involvement in a Developing System of Care<sup>8</sup>*

Professional Focused	Family Focused	Family Allied	Family Centered	Team Centered
<p>On one end of the family service continuum is the professional stance that considers the professional to be the expert and views the family as a hostile resistive force in the way of achieving professional goals. The professional parent relationship is unfriendly, viewed as adversarial, with the parent as the problem. This attitude results in the view of the family caregiver as someone who can be taught or treated. The parent must adapt to the professional's service values.</p>	<p>The professional philosophy views the professional as expert with families as helper and allies to the professional. The professional knows best and the relationship to the parent is one of getting the family caregiver to become a partner in helping the professional. The caregiver is "one down," because the professional decides the rules and roles, and the caregiver is merely an agent of the professional.</p>	<p>Families are viewed as the customer in the service delivery system. Professionals strive to attune the services to the needs and desires of the family who is their customer. The family caregiver is seen by providers as an equal colleague, one who has expertise, knowledge, and choice. Professionals and caregivers work collaboratively to address mutually agreed upon goals.</p>	<p>Practice at this level of the continuum puts professionals "one down" to the family caregiver. The philosophy is that the parents know what is best for themselves and their children. The philosophy is that professional's services exist to support parents as the primary agent in helping the child achieve his or her goals. The family is seen as the employer and the professional as the employee. The professional asks, "How can I help you? How can I be of service to you? What do you need?"</p>	<p>The wraparound model centers decision making with the team. Team strengths and resources (which include those of the provider as well as family and child) are collected and used to select intervention most likely to work. Both planning and intervention rest on the combined skills and flexible resources of a diversified committed team. Responsibility for decisions rests with the collective power of the team working together, supporting each other as well as supporting the family.</p>

# MENTAL HEALTH CARE

## ***What happens when someone has mental health problems?***

For children and adults alike, mental health problems are real and painful. Mental health problems can change the way any person thinks, feels and acts. Children with mental health problems may have serious school problems, feel bad about them selves, be very fearful or nervous, or use poor judgment. Poor mental health can lead to other problems like fighting, drug use, loneliness, and suicide.



## ***What causes mental health problems?***

There is no easy answer to a question about the causes of mental health problems because there can be many causes. Some of the causes are biological, some are environmental, and some are both. Biological causes are there at birth. They may involve genetics, an imbalance of chemicals in the brain, or damage to the central nervous system. Environmental causes are the events that happen in a person's life such as death of a family member, trauma, abuse, poverty, or even exposure to chemicals.

## ***What can I expect if my child is referred to a mental health center for services?***

In the past, North Carolina's mental health programs offered direct services to children and their families. Under the new Mental Health Reform, these mental health programs' roles have changed to help manage and develop a variety of services and supports across the community through private providers. Children and their families now have more choices in selecting who will deliver their services and supports, and the range of services and supports is increasing. Local mental health programs are now known as 'Local Management Entities' and the providers are known as the Provider Community. Now, when families seek services and supports in any county in North Carolina, the process should be about the same from one county to another.

Each community must now provide a quick-access screening process to help families determine whether their child and/or other family members need mental health services and how to get them. "No wrong door" is applied to how a person receives services. That means that you should be able to access mental health services through private providers, public providers, hospitals, and family doctors. The Local Management Entity (LME) will be the gatekeeper to public mental health services. Upon arriving at the door, you can expect the first step to be the sharing of information. You will be asked questions about your child and family, including your income. The staff will

describe mental health services and answer your questions. They will also give you information about your child's rights under the law.

You will be asked to sign some forms to give permission for mental health service providers to treat your child and share information with other agencies. You will also be given information about the cost of services. After this screening is provided, and it is determined that mental health services are needed, the family will have a choice of providers to work with them to plan, deliver and monitor services that build on strengths and meet their particular needs. Families should expect to be fully informed about which providers offer which services and assistance in finding the 'best fit' for their unique strengths and needs.

### ***Who provides mental health services?***

As North Carolina continues to develop its Mental Health Reform, services are provided by various private provider agencies. Each Area Program or Local Management Entity works with different providers in their community, creating a Provider Community. As noted above, this allows families to have more choices in who provides their services. Families and consumers can select their care providers and/or change providers to get the best fit in meeting their family's particular strengths and needs. A provider may be identified through: Local Management Entities, brochures, medical doctor/pediatrician, co-workers, family, friends, employee assistance programs, local school district, Department of Social Services, web sites, other child serving agencies, hospitals, advocacy organizations, yellow pages of phone book, NC Council Resource Guide, and consumers of services. Service providers for the LME will go through a process of endorsement in order to have consistent, quality providers available.

Do some investigating - check with Division of Facility Services to see if there are any complaints against a provider. You can call them at 919-515-2732 or visit their website at [www.dhhs/facility-services.state.nc.us](http://www.dhhs/facility-services.state.nc.us)

### ***When does the System of Care process begin if my child has mental health needs?***

After the screening process occurs, an intensive clinical and functional face-to-face evaluation occurs to determine whether the individual meets the "Target Population" to be eligible to receive mental health services. The face-to-face evaluation is a part of the Diagnostic Assessment. At least two qualified mental health professionals will make the determination of eligibility to receive services. Usually, the professionals are a MD, PhD Psychologist, Physician's Assistant, and/or Nurse Practitioner.

If your child and family are eligible (meet Target Population status) to receive Enhanced Benefits, you can expect a case manager (or, under new Service



Definitions, a Community Support Team Coordinator) to contact you shortly after your child becomes eligible for services. That individual will most likely work with you as your Child and Family Team Facilitator, beginning the System of Care process for children eligible for Enhanced Benefits under Mental Health Reform. A Child and Family Plan, using a person/family-centered approach, will be developed through your Child and Family Team. The process is described in this handbook.

### ***What are the roles of mental health professionals?***

Mental health professionals such as social workers, case managers, therapists, counselors, psychologists, and psychiatrists can help identify special mental health challenges and needs, and help to figure out the best treatment to address them. These professionals should participate as active members of each Child and Family Team so that all services and supports are coordinated for your child and family. Listed below are their specialties:

- ◆ Psychiatrists - Medical doctor that specializes in psychiatry and can write prescriptions.
- ◆ Psychologist - Specialist in Psychology that do testing, evaluation, assessments, psychological theory, research methods, psychotherapeutic, techniques. Usually responsible for developing behavior plans
- ◆ Social workers - Help individual, families and communities overcome a variety of social and health problems. Most have their master's degree in social work.
- ◆ Psychiatric Nurse - A Registered Nurse (RN) with extra training in mental health. They work with individuals, families or communities to evaluate mental health needs and assist other mental health professionals in treatment and referral.
- ◆ Other Mental Health Providers - (community support professionals/paraprofessionals)
- ◆ Couples and family therapist - May be a psychiatrist, psychologist, social worker or nurse
- ◆ Pastoral counselor - Member of the clergy who integrates religious concepts with training. This professional does not require a license.

{Adapted from Mental Health Providers: Making the Right Choice: MayoClinic.com}

### ***Who decides about services?***

When your Child and Family Team meets, you may identify many services, supports and resources that are needed. It is likely that your team will decide that professional mental health services are needed. Your Child and Family Team can help you with this process. If the all of the services that your child needs are not available,

your CFT should put together a Child and Family Plan that includes those services and supports that are available, and your CFT Facilitator should seek assistance from the local Community Collaborative to help figure out how to modify an existing service to meet your child's needs or determine how the community could create the needed service.

### ***What kinds of help can I get from mental health service providers?***

Each community may have some differences in the types of mental health services available. In general, mental health provider agencies offer testing, counseling, treatment, planning, education and training, crisis management, care coordination and management of services. The specific nonresidential and residential services that are offered by many mental health providers are described below.

#### **Non-Residential Services**

*In a System of Care, every effort is made within the community to develop the types and number of non-residential services that children and their families need to remain together, for the child to remain safe at home, in school and in the community. Providers of each of these services should be expected to actively participate in the Child and Family Team process.*

- ◆ **Prevention Services** - Programs and education to keep small problems from developing into big ones.
- ◆ **In-Home Family Services** - Education, support, counseling and training to help parents learn how to understand their children's problems, how to help their children, and how to cope.
- ◆ **Care Coordination and Management** - A service that helps families arrange and organize their children's services from many agencies. Care managers are usually the individuals that work with children and their families to organize and run Child and Family Teams. (Formerly, Case Managers were responsible for coordinating mental health care in Child and Family Teams. Under North Carolina's Mental Health Reform, a service called **Community Support** is now available. This combines case management and one-to-one mentoring type services.)
- ◆ **Day Treatment** - A program for children who can't manage a public school setting, usually because they need very close supervision in a therapeutic setting.
- ◆ **Outpatient Treatment** - Services such as screening and counseling for children who may have less severe problems and who can get along in their home setting. Outpatient treatment may also be combined with other services when challenges and needs are more serious and complex.

## Residential Services

*In a System of Care, out of home or residential services are used as a last resort - only when nonresidential services are not enough. Residential services are intended to be short-term and used to help reach very clear goals in order to successfully reunite children with their families, schools and community. Providers of each of these services should be expected to actively participate in the Child and Family Team.*

- ◆ **Respite** - Children stay in a temporary, safe, stable environment on a planned basis to help give families a break from care giving in order to help keep the child in their home over the long term. There are also emergency respite services that can be available when there is a crisis at home.
- ◆ **Therapeutic Foster Care (also called Level II Homes)** - Children live in a home with trained therapeutic parents. There are usually no more than 2 or 3 children in the home. Many Level II providers will work with Child and Family Teams to find a best fit, including having no other children in the home.
- ◆ **Group Homes (also called Level III Homes)** - Children live in a home with other children, often with 6 or more other children, who need treatment in a more intensive place. They are closely supervised and receive many services such as counseling and social skills training. They usually attend public school.
- ◆ **Inpatient Treatment** - Children are treated in a hospital setting where they receive psychological and medical treatment.

### *How do I know what services are the best for my child?*

Families should try to become informed about what works and what doesn't work to help children and their families. For example, over the past few years, there has been a growing effort to understand, through research, which services and interventions make a positive difference for children. You may have heard the term 'Evidence Based Practice', which is the result of this research. Evidence Based Practice (EBP) refers to growing scientific knowledge about treatment practices and their impact on children with emotional or behavioral challenges. North Carolina's Mental Health Reform requires that services provided to children and their families, whenever possible, be supported by evidence of effectiveness. While not every community has fully developed an array of Evidence Based Practices, it is important for families to become informed about this growing body of research. There are a many sources of information about Evidence Based Practices; one of these, written for families, Michigan's 2004 Association for Children's Mental Health manual for parents on Evidence Based Practices<sup>9</sup> provides the following description of Evidence Based Practices:

"Varying criteria exist for a treatment or intervention to be considered evidence based. One common criterion is the efficacy of practice. There are two requirements for any practice to be deemed efficacious (effective). 1) The study must use a treatment manual. 2) The treatment group has, at a minimum, been compared to a non-treatment control group and that the outcomes for those in treatment group were better than the outcomes of those who received no treatment."

◆ **Cognitive Behavioral Therapy (CBT)**

CBT has been demonstrated to be one of the most effective treatments for youth with depression. It teaches youth how to change their thoughts and behaviors so they can change the way they feel. The result is a decrease in their depression. It is one of the few psychosocial treatments for depression shown to be effective in random clinical trials. It has been shown to be as effective as antidepressant medications for mild to moderate depressions in some clinical studies.

◆ **Parent Management Training (PMT)**

PMT helps parents develop the special skills needed to successfully support and maintain their children at home and in the community. These skills are sometimes described as 'advanced child behavior management skills.' The techniques taught are based on social learning principles that assist families in understanding how positive and negative behaviors are developed and maintained by their consequences.

◆ **Multi-Systemic Therapy (MST)**

MST is a program designed to target youth between the ages of 12 to 17 who have long-term (chronic) violent or substance-abusing behaviors and have become juvenile offenders. Treatment should emphasize the positive and utilize strengths as opportunities for change. This program promotes responsible behavior to decrease irresponsible behaviors, targets well-defined problems, and changes the sequence of behaviors that contribute to identified problems. Frequency and duration of sessions are determined by family need and are usually provided in the family home. Therapists usually have 60 hours of contact with the family over approximately four months.

◆ **Multi-Dimensional Treatment Foster Care (MTFC)**

MTFC was developed from the foundation of Parent Management Training (PMT). The important components are:

- Increased supervision
- Positive adult-youth relationship
- Reduced contact with deviant peers
- Family management skills

This program attempts to decrease covert and overt anti-social behavior, 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."

Another key service that is supported by research for effectiveness is **Intensive Case Management**<sup>10</sup>. Intensive Case Management was developed to work intensively with a child's family and coordinate with teachers and other helping professionals to develop an individualized comprehensive service plan. The case managers are specially trained to assess and coordinate the supports and services necessary to help children and adolescents live successfully at home and in the community. There is a 24-hours a day, 7-days per week response capacity. The number of children and families the case manager works with is small, no more than 15 at a time, and less if more intensive services are necessary. Case management or similar mechanisms (now called 'Community Support Services for Children and Adolescents in North Carolina's new Service Definitions) are essential to ensure that multiple services are delivered in a coordinated and therapeutic manner and that so children and their families can move through the system of services in accordance with their changing strengths and needs.

In North Carolina, case managers have long played the role of family helpers and advocates, by helping families obtain and coordinate services for their children. Many child serving agencies have staff that provide case management services, including mental health providers, local Departments of Social Services, local School Systems, etc. In a System of Care, a case manager/Community Support provider often takes on the role of the Child and Family Team Facilitator, but there is also a growing movement for parents to take on the facilitation role as well as to have independent facilitators. In any case, as communities in North Carolina progress in developing strong and effective local Systems of Care, the Child and Family Team Facilitator role is a key role to better promote the strengths and meet the needs of children with behavioral, education and safety challenges, and their families.

An area of growing concern and interest about how children get along at home, school, and in the community is the impact of trauma. Trauma (from deaths in the family, from abuse or neglect, from exposure to violence, etc.) can have a profound impact on how children function in their everyday lives. Trauma can be at the root of many problems including depression and acting out behaviors, but is often overlooked in assessment, diagnosis and treatment. There are special interventions and approaches

that are most effective for assessing and treating trauma issues. You can find more information about trauma in the "Trauma Information Pamphlet for Parents" at the end of this Handbook.

### ***How do I know if the right services are being provided?***

Families are the experts on their child. Families know best what their child and family needs. Families should feel comfortable and be encouraged to ask questions about services and interventions. Some approaches to consider include<sup>11</sup>:

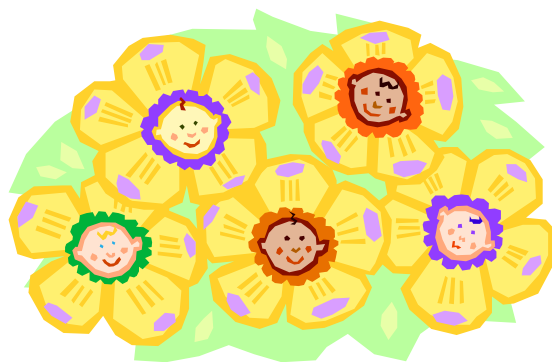
- ◆ Ask for all available information about a suggested service or intervention for your child and family.
- ◆ Evaluate how services so far have worked with your child and family. Have they helped?
- ◆ Discuss using a service or intervention with your Child and Family Team, with other families, with a trusted provider who knows your child and family. Family involvement is critical to the success of services and interventions for children. Decisions about your child's treatment and support services should be made after thorough discussion whenever possible.
- ◆ Use a service or intervention on a trial basis. At the end of the trial period, the child'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 'take effect'.
- ◆ Some specific questions to consider asking and discussing with your Child and Family Team and professionals providing services to your child:
  - Is this an Evidence-Based Practice? If so, is there a description of the practice and how it works?
  - 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?

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

There are many services available in North Carolina's System of Care. Some services are formal services you get through agencies like mental health clinics or in-home counselors. Other agencies, such as local Departments of Social Services, Public Health,

the Department of Public Instruction, the Administrative Office of the Courts, and Juvenile Justice provide services that some children and their families need. Some services are informal supports you get in your community from clubs, churches, recreation centers, friends, and family members. In a System of Care, all of these services and resources become integrated for a child and his/her family through on unified Child and Family Team. To learn more about resources for your child in your community, you can:

- ◆ Ask your family advocate or Child and Family Team Facilitator
- ◆ Get involved in your local Community Collaborative
- ◆ Get referrals from professionals
- ◆ Call your local parent support network
- ◆ Call your local mental health center/Local Management Entity
- ◆ Tell people what you want and what you think your child needs



# Child and Family Teams

## ***What is a Child and Family Team?***

A Child and Family Team (CFT) is a group of people that meets with a child and family to set goals and plan services. The CFT is built around the family to make sure that each family's strengths are promoted and their needs are met. Team members work together with the family to write a Child and Family Plan based on what the child/youth and family wants and needs.



## ***Who is on a Child and Family Team?***

The family is always part of the CFT. Children who are old enough to attend meetings, understand the process, and make choices can be on their own CFTs. The team can include anyone who is important in your life and who knows the strengths and needs of your child and family. Team members are usually people who are part of your child's education, care, custody, or treatment, and others who know your 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
- ◆ Family advocates
- ◆ Service providers (doctors, social workers, case managers, court counselors, teachers, school nurses, etc.)
- ◆ Others who know your family well

## ***What is a family advocate?***

Everyone on your Child and Family Team will be helpful and supportive, but the family advocate has a special job to guide and support you as you learn your role as a team member and become active in the System of Care. Your advocate can help you get information, choose service providers, solve problems, and get ready for meetings. Your family advocate can also help you get in touch with other parents to share ideas and experiences. The family advocate usually is a parent of a child with special needs and can provide support and empathy because of having walked in similar shoes like those you find you are wearing.

### ***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 you begin getting more of the support and resources that you need through the System of Care, you may need fewer professionals and want more members who are family members and other family supporters in your neighborhood and community. One of the goals of System of Care is to help families become more confident and able to meet the needs of their children without relying only on paid professionals.

### ***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.

### ***Who chooses team members?***

Families choose their team members with help from their Child and Family Team Facilitator or Case Manager. You can also ask your family advocate or others who know your child and family well to help you choose team members. However, if your child is under the legal supervision of the courts, juvenile justice, or social services, representatives from those systems must be part of your CFT.

### ***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 does the Child and Family Team do?***

The CFT plans services to support the child and family. The CFT checks to make sure services and supports are working, resources are available, and suggests changes if the plan is not working or if different services are needed.

### ***What is the job of the CFT Facilitator?***

The Child and Family Team Facilitator has many responsibilities to help organize and manage the CFT and the planning process. Part of the facilitator's job is to set up and lead team meetings. If someone misses a meeting, the CFT Facilitator makes sure that the person provides information for the CFT to consider and knows what happened at the meeting. The CFT Facilitator also makes sure everyone knows about any changes in the Child and Family Plan.

Part of the facilitator's job is to gather and share information with all team members who are working with you and your child. The facilitator makes sure that all of the people working with you know about your Child and Family Plan and are doing their jobs to carry out the plan. The facilitator is also responsible, along with your 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 adjust the Plan. The child and family are not seen as non-compliant but the plan is viewed as needing adjustments.

### ***Who chooses the CFT Facilitator?***

The CFT Facilitator is usually a service provider from one of the agencies that is working with you and your child. In most cases, the CFT Facilitator is also your case manager, care coordinator, or social worker. If your child is eligible for mental health services in the System of Care, the case manager will work for a private provider agency. However, you might also receive certain services from the local Department of Social Services, in which case, an individual from Social Services could be your CFT Facilitator. In some cases, an individual from your child's school might be your CFT Facilitator. It depends on what services your child needs and is eligible for and which agency is most involved in meeting your family's needs. Your family advocate and other team members can help you identify the CFT Facilitator.

### ***Who can ask for a CFT meeting?***

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. If your child has a change in his/her living situation, or another significant life event is occurring for the family, it is always good to have a CFT meeting to make sure you have the services and supports needed to help with the new situation. If there is a crisis, the family or another team member might ask for an emergency meeting. Team members who can't attend an emergency meeting are expected to share their ideas and opinions by phone.

### ***When should I ask for a CFT meeting?***

You should ask for a CFT meeting whenever you feel your child's plan needs to be changed, there is a problem to be solved, or a crisis occurs. You also might call a meeting when you want to check progress.

# Child and Family Plans

## ***What is a Child and Family Plan?***

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



- ◆ A description of warning signs for a crisis for your child
- ◆ What each team member will do to help you and your child avoid a crisis
- ◆ What each team member will do if a crisis does occur

You should expect your Child and Family Plan, including your Crisis Plan, to be very practical and easy to understand. 'Call 911' is not acceptable as the only strategy for a Crisis Plan!!

Different agencies may have different specific plans or names for plans for services to children. For example: the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services uses Person-Centered-Plans to develop behavioral and related services and supports for those eligible for Enhanced Benefits; public schools develop Individual Education Plans for children eligible for certain services within the school system.

## ***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 a special plan (family-driven and child-directed) for your 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 big advantages of System of Care for children and their families is the emphasis on coordination and integration of services and supports. In a System of Care, 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.

The agencies that may provide services for your child and family have certain requirements that they must accomplish. For example, if your child has a learning

disability and has an Individual Education Plan, your school system must complete certain activities and forms to be in compliance with the law. However, your Child and Family Plan is the big umbrella plan for your child. This plan should include *all* of the services from all agencies that support your child. The strengths, goals and needs regarding school that are in your Child and Family Plan should be built into your child's 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 several different meetings or have several different plans for their child and family.

### ***How is a Child and Family Plan developed?***

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

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

First know the values and guidelines for a Child and Family Plan (see appendix of this book). Next, begin the process:

#### **Step 1**

Someone asks to hold a Child and Family Team (CFT) meeting. Your family chooses members of the CFT. Your CFT Facilitator and your family advocate can help you decide who should be on the team.

#### **Step 2**

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

#### **Step 3**

Your CFT meets to write your Child and Family Plan, including a Crisis Plan. All members sign the plan to show that they agree with and will do what it says. All members have a copy of the plan.

#### **Step 4**

Everyone uses the plan. They do what the plan says they will do. They check to see what's working and what's not for each goal.

#### **Step 5**

The team changes the plan if changes are needed.



## Step 6

The team keeps checking to make sure the plan is working

### ***How do I know the plan is working?***

It may take a while to see results, but after most services have started, you should begin to see and feel a difference. The differences may be small at first, but in general, everyone should feel organized and more in control. You will know the plan is working when you see progress toward goals and your child is getting better.

### ***What can I do if the plan isn't working?***

First of all, be patient. It may take a while 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 that you are not satisfied. The CFT Facilitator should then contact the service provider agency to help make changes. Each agency has its own steps to let the right people know that you want to make changes. Talk to your CFT Facilitator or your family advocate to find out the best way to let the right people know your concerns.

### ***What is a Crisis Plan?***

Sometimes, in spite of everyone's best efforts, problems arise that need immediate attention. In a System of Care, Child and Family Teams help families try to avoid crises and help if a crisis does occur. A Proactive Crisis Plan is an action plan that tells everyone how to avoid a crisis and a Reactive Crisis Plan is an action plan that tells everyone how to manage an actual crisis situation.

The child and his/her 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. The Proactive Crisis Plan should identify the triggers that typically set off a crisis, including the child's crisis behavior. This Proactive Crisis Plan indicates who will do what to avoid the development of such crises.

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. This is the purpose of a Reactive Crisis Plan - how team members react when a crisis occurs. The Reactive Crisis 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 backup services will be used to help the child and family. If safety is an issue, a crisis plan always includes strategies for keeping the child and his/her family safe. Without a Crisis Plan, a child

often ends up in an institution or residential placement when this could have been avoided. Such plans help everyone respond effectively and make it possible for life to return to normal as quickly as possible. Your Child and Family Team should review the Proactive and Reactive Crisis Plan at each CFT meeting and make changes as your needs or circumstances change, such as changes schools, changes his/her place to live, if a member of the family becomes seriously ill, etc.

### ***Example from a Backup or Crisis Plan***

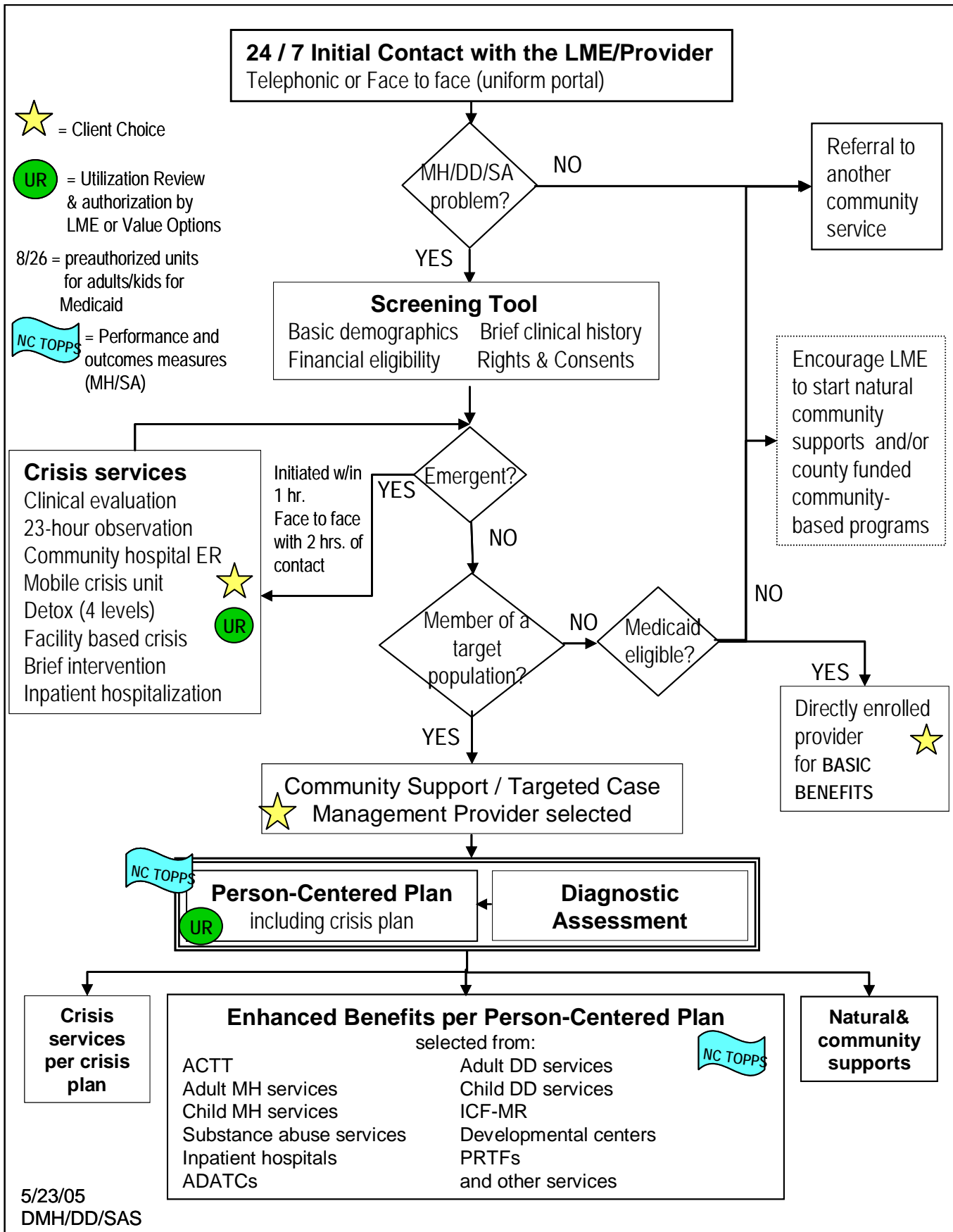
Carl gets into serious trouble when he runs away from home. He steals cars, uses drugs, and hangs out with a gang. If Carl runs away from home:

- ◆ His grandfather, the person he listens to best when he is upset, will be notified immediately.
- ◆ His grandfather will notify the police and work with them to find him and talk to him.
- ◆ When Carl returns, he will be put on 24-hour watch. Someone will escort him to and from school and be with him all day. He will be at home or with a parent after school.
- ◆ The family will meet with the CFT Facilitator and Carl's therapist to help him learn what to do when he gets the urge to run.
- ◆ The CFT will call an emergency meeting to re-examine the Child and Family Plan and determine why the current plan isn't working and how to change the plan to better meet Carl's needs. For example, how can he be kept busier with pro-social activities? How effective is his drug treatment? Is there a mechanic that can work with Carl to work on cars instead of stealing them?

### ***Why is a Crisis Plan important?***

A crisis plan is important because it helps everyone avoid potential crises and cope in a crisis situation. A Crisis Plan helps everyone react quickly to keep a problem from getting worse; it makes it possible for life to return to normal as quickly as possible.

The next page shows the graph for access to services, including crisis care, within the Mental Health, Developmental Disabilities and Substance Abuse system. Crisis services are a core service that everyone with such challenges and needs should be able to access. See the example on the next page describing how to access services, including crisis services, within Local Management Entities (furnished by DMH,DD,SAS).



## Child and Family Team Meetings

### *How do I get ready for a Child and Family Team?*

Your Child and Family Team (CFT) Facilitator will meet with you before the first CFT meeting to talk about what is important to your family and what you hope will change for the better. You and your CFT Facilitator will also talk about your family's strengths. Strengths include family values, what your family likes to do, and what your family does well.



You will tell the facilitator who you think will be helpful to you and your family so the CFT Facilitator can help you choose people to be on your team.

### *Who is on a Child and Family Team?*

This is different for every family, since every family is unique. Your Child and Family Team should be made up of those individuals who are important in the every day lives of you and your child - those persons who can help you, your child, and your family meet your goals through a Child and Family Plan. However, you (parent/legal guardian) must always be part of your Child and Family Team. In fact, the CFT should never meet without you. You and your CFT can decide when your child attends CFT meetings, but he/she is also a member of the CFT. You should also have a CFT Facilitator, someone to help organize and manage the CFT, making sure that things planned and agreed to actually take place, and that the plan changes as needed. The members of your CFT should change as your needs change, and according to your priorities. (There is one exception: if your child is under supervision of Social Service, Juvenile Justice, or there is a court order requiring the involvement of certain individuals in his/her life, those persons must be represented on your CFT.)

For example, if your child is struggling in school, someone who knows and can help your child from the school should be on your CFT. If your child has a mental health professional working with him/her, that person should be on your CFT. If your child is under the supervision of juvenile courts, someone from that system must be on your CFT. However, CFTs are not just for 'professionals'. It is just as important to have other individuals important to you and your family on your CFT; for example, a neighbor that you turn to for support, a member of your church or synagogue, other family members, such as aunts, uncles, grandmothers. The members of your CFT should be those persons who can help you and your family reach your goals. As your goals are achieved or change, you may need other persons on your CFT to meet new goals. This way, everyone who is working to support you and your family works together on one

team, all at one time, so that you do not have to go to each person or organization to get the help and support you need.

### ***What happens at Child and Family Team meetings?***

At the first Child and Family Team (CFT) meeting, your team writes a plan for services and support. The team meets after that to review and change the plan as needed. Sometimes the team meets if there is a crisis that needs special attention.

### ***How long is a meeting?***

The first meeting usually lasts about one and a half hours, but can last longer. It depends on the needs of the family. Follow-up meetings usually take less time.

### ***How often do we meet?***

Follow-up meetings are about once a month or as needed. "As needed" means that you can meet more than once a month or less than once a month according to how well the plan is working.

### ***What is my role on the team?***

Your role is to speak out to help the team write a plan that really serves your child and family. You do that by letting the team know what you need, what you want, and what "works" in your life. You guide the team to find resources and services that really fit your child and family.

#### ***Example***

*One of the outcomes that you would like to see for your family is that your child gets along better with his younger brothers. Your CFT is helping you think about ways to accomplish this. You are asked to help the team understand the strengths and interests of your children to help develop a plan to build on these. You explain that all three boys like camping and fishing. The boys seem to relax and get along better when they are outdoors. You are most likely the only one at the meeting who knows that kind of information. It is your job to tell the CFT about that family strength and to suggest camping activities as part of the plan or as a reward. Another outcome that you see as important for your son is to increase his ability to manage his anger. You ask the CFT to talk about counseling for your son. You know that he had a difficult time with a female therapist last year. Your job is to tell the team what has worked or not worked in the past and to suggest what might work better this time.*

### ***Who will help me if I don't know what to do?***



You are part of a team, so everyone helps each other. You can ask any team member, your family advocate, or your CFT Facilitator for help whenever you have a question or have to make a tough decision. Each step along the way, you can ask your team for information and help. You should be able to count on your team to understand your strengths, challenges, needs and concerns.

### ***Who sets up the meeting?***

The CFT Facilitator contacts all the team members to set up a meeting. Anyone can ask the facilitator to organize a meeting.

### ***How are decisions made at meetings?***

Your team will have a process for discussing issues and reaching agreement. Teams try to have everyone agree about decisions. If the whole team doesn't agree, it's the Facilitator's job to help resolve disagreements. If disagreements are not getting resolved, your team may need the help of supervisors, a neutral mediator, or a trained CFT or wraparound coach.

### ***What happens at the first meeting?***

At the first meeting you will:

1. Review the outcomes your family wants to achieve;
2. Review your family's strengths, assets and preferences;
3. Find out what your family wants to improve and what you need to overcome any barriers to make these improvements;
4. Develop a plan to help you get what you need to accomplish the outcomes.

### ***What are the exact steps of the meeting?***

#### **Step 1. Meet the team**

Everyone will introduce themselves and tell how they know your child and family. Sometimes team members will say how they think they can help and what strengths they bring to the team.

#### **Step 2. Talk about your family's goals - the outcomes you want to achieve**

Your CFT Facilitator will ask you what you want to achieve for your child and family. The facilitator may ask you to look into the future and talk about how you would like things to be different in six months or a year.

#### ***Examples of Goals/Outcomes***

#### ***A parent might say:***



*"In six months I want my son to go to school every day and get along with other kids."*

*"In six months I want my daughter to tell me when she is upset before she loses her temper and hits her sister."*

*A child might say:*

*"In six months I want to have a job."*

*"In a year I want to be living with my family all the time."*

Meeting these outcomes will determine whether or not your Child and Family Plan is working. They should be reviewed at each CFT meeting. If these outcomes are not being met, the team should discuss whether the plan needs to be changed.

### Step 3. Talk about your family's strengths

Your team will share what they know about your family's strengths, assets, and preferences. This is a chance for all team members to get to know your family better. The CFT Facilitator will review your family's strengths, assets and preferences and write them on a flipchart. Team members may add things to the list. (See the section on Family Strengths in this handbook.) The team will work with you to use your strengths, assets and preferences to help achieve your goals and outcomes.

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

Your team will help you choose the areas of your child's life you want to plan for first. Usually families choose the two or three areas that are most troubling right now.

Some areas (life domains) are:

- ◆ Behavior - how your child acts and feels and how he gets along with others
- ◆ Health - physical (and dental) well-being or illness and any medical or other health care that is needed
- ◆ Education - how, what, and where your 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 your child lives
- ◆ Legal - anything related to laws, rights, courts, probation, and custody
- ◆ Safety - protection from harm to self or others

*NOTE - When children or families are required by law to be involved in certain services (for example, Child Protective Services or Juvenile Court services), these requirements must be a top priority for the Child and Family Team and the Child and Family Plan.*

### Step 5. List and prioritize your needs

Say what you think needs to happen in order to reach the goals.



### *Examples*

- ◆ *In order for Bruce to meet the goal of succeeding in school, he will NEED to be able to follow school rules and do his school work.*
- ◆ *In order for Kendra to improve her social relationships, she will NEED to get a driver's license.*

### Step 6. List any challenges or barriers and who can help

What stands in the way of getting these needs met? Who can help you address these challenges and help you get the services, supports or resources that you need? Are those people on your CFT? Your CFT Facilitator will help contact any individuals who need to be on the team.

### Step 6. Develop strategies for each need you identified

Strategies are the action steps that say how each need can be addressed so that barriers are overcome and goals can be met. The best strategies are those that use existing strengths to overcome challenges and meet a need. You and everyone on your Child and Family Team will offer ideas about what strategies to use. Then the team will help you choose the best strategies to write into the plan.

### *Example*

- ◆ *Bill says he is lonely and wants to make new friends. (need)*
- ◆ *Bill is very shy in social groups (challenge/barrier)*
- ◆ *You know that Bill is a good runner and enjoys being outside. (strength & preference)*
- ◆ *One action step (strategy) could be to help Bill join the track team.*
- ◆ *The track team coach might be the best person to carry out the action step.*
- ◆ *Enlist the track team coach to help Bill find a role on the track team, with the CFT's support.*

### Step 7. Develop a Crisis Plan

The team will write another plan that spells out what usually happens when a crisis is brewing, including the 'triggers' that have set off crises in the past. They will spell out who will do what to defuse such a crisis. There is also a plan developed that spells out who will do what if a crisis or an emergency does occur. The crisis plan is a safety net. It tells everyone what to do to help you help your child when the usual strategies are not working.

### Step 8. Make assignments

Each team member will have a job to help carry out your Child and Family Plan. Some team members will help your child directly at home, at school, or in the community. Some

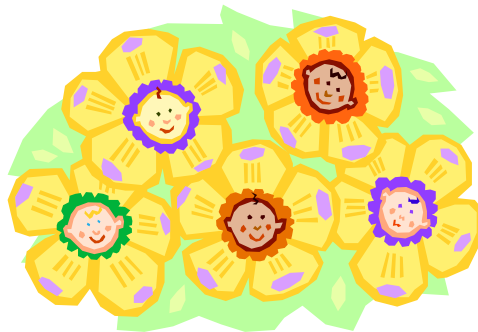
team members will get more information or talk to others and get them to help. Of course, you and your child will also have assignments since you are key members of the team.

*Example of an Assignment*

*Mrs. Crisp, the school counselor, will meet with all school staff that work with James to tell them about the plan and a new behavior contract. She will teach them how to use the contract, record points, and help James succeed in his behavior contract.*

Step 9. 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?*

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 service providers' view and work with families. For the past fifty years, professionals have been taught and reinforced for identifying problems and offering solutions - building a problem-focused approach. Gradually, more and more human service providers are making the shift to a strength-based orientation. The family strengths approach encourages service providers and entire service 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 competencies 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 competencies they need.
- ◆ Families with problems are not "broken" and "needing to be fixed." A strength-based orientation means that families are approached in ways that focus and build on the positive aspects of functioning. Providers 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 professionals are not viewed as experts that are expected to solve a family's problems.

Working with children and families as full partners not only makes good sense, but is beginning to be supported by research as making a positive difference to achieve better results for children, families, and professionals assisting them. Portland State University gathered the following findings<sup>12</sup> about challenges, needs and results of family partnerships within service planning and delivery teams: 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 child-directed, it is more likely that the plan will meet the individual needs of the families, build on their strengths, and respect their culture.

However, there are many challenges to making this 'best practice' a reality. Part of the challenge is the 'power differential' between family members and 'professionals' on teams. Even if family members have relatively high status outside of meetings, their status within meetings is likely to be deflated because of team members' tendency to see the family in terms of its needs and deficits. Most teams need specific, concrete ways to make sure the family's perspective is truly represented in the planning process. Some of these strategies can include:

- ◆ Provide opportunities for family members to speak first and last during discussions
- ◆ Checking back in with families after any decision
- ◆ Using a family advocate to support the family perspective
- ◆ Encourage families to 'tell their stories' at the team meetings
  - A family's story can contain important information about hopes, goals, strategies and resources
  - Families can talk at each meeting about how things are really going
- ◆ Supporting families to 'tell their stories' by allowing them to talk in an open-ended, narrative way about their experiences helps them and their team get the bigger picture and gauge what's working and what's not working.

If your community is not using some of the strategies described above to help create true family partnerships and to promote family voice and choice, you may want to help them figure out ways to change these practices so that everyone gets better results. You could consider talking to your CFT Facilitator and your 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 it strong. Family strengths can be little things like watching TV together, or big things like sharing chores or solving problems together.

### ***What is a strengths inventory?***

A strengths inventory is a set of questions to help family members think about their strengths and preferences. An inventory is not meant to pry into personal issues. It is meant to help family members talk about all the activities they like to do, how they like to do them, and everything they do well. It also helps families think about the people in their lives who can help and support them.

### ***Will I complete a strengths inventory?***

Before your first CFT meeting, your Child and Family Team Facilitator will ask you questions to learn about your family's strengths and preferences. In the System of Care, services and supports are built around family strengths and preferences, so it will be helpful for you and your team to talk about these from the very beginning.

### ***What if I can't answer the questions?***

Don't worry. A strengths inventory is not a test. There are no "right" or "wrong" answers. You may think of some strengths and preferences as you get to know your team better and feel free to bring them up then. Also, your team members may help you identify and remember strengths that you have forgotten.

### ***What if I don't want to answer the questions?***

You can say as much or as little as you want. Most people really like doing a strengths inventory because it gives them a chance to think and talk about what they like to do and the good things in their lives.

### ***What kinds of questions will I be asked?***

A strengths inventory asks questions to help you think about many different kinds of family strengths and preferences. Some examples are:

- ◆ What does your family do for fun?
- ◆ What makes you laugh?
- ◆ What is one thing you really like about your family?
- ◆ Whom do you talk to when you have a problem?
- ◆ What is your neighborhood like?
- ◆ How do you prefer to get together with friends?
- ◆ What times are best for you to talk through how things are going for your children?

### ***Can I do a strengths inventory on my own?***

Certainly you can think about your family's strengths and preferences whenever you want to, but most people don't. People usually think about "problems" and what needs to be "fixed." It's a good idea to start thinking about all the things that are "working" and how they can be used to make life better.

### ***Does every family have strengths?***

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

## ***What are some examples of strengths?***

Family strengths are all the activities, habits, skills, interests, attitudes, and behaviors that make your family strong and help you cope.

### Examples of Family Strengths

- ◆ Talk openly about problems
- ◆ Have friends and close relatives who can help
- ◆ Share chores
- ◆ Eat meals together
- ◆ Know how to have fun (games, sports, TV)
- ◆ Laugh together
- ◆ Stand up for (protect) each other

### Examples of a Child's Strengths

- ◆ Enjoys explaining how things work to younger children
- ◆ Has a good sense of humor
- ◆ Able to find things that others lose around the house
- ◆ Likes to draw and paint

### *Example of a Hidden Strength*

*Bud talks back to his mother. That's rude behavior. But it is good that he can speak his mind. Bud should learn better ways to speak out, but he has the strength of being able to let others know what he is thinking.*

## **Team Strengths**

### ***How can I be sure I am choosing the best people to be on my CFT?***

There are many people who can be helpful to you and your child, but some will be better than others for your CFT. You should think about what you want your team to do, then choose people who have the knowledge, interest, and skills to help right now.

### ***What are team strengths?***

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

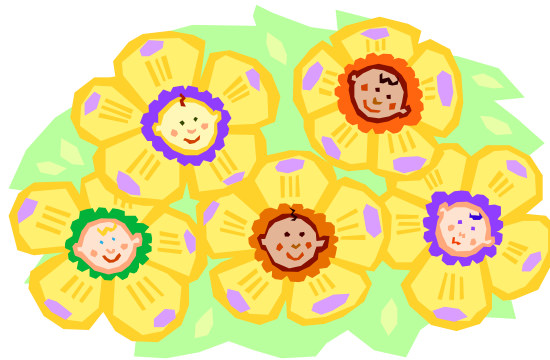
## ***How do I know my team's strengths?***

You already know something about the people on your team, but you may want to ask them a few questions to find out more. You can give your team a strengths inventory to help everyone learn more about how they can help.

### ***What questions should I ask?***

You can ask team members questions about their interests, their experiences, and why they want to be on your team. Use some of the questions below or make up your own.

- ◆ What special training or skills do you have that will be useful for my team?
- ◆ Have you written Child and Family Plan like this before?
- ◆ How do you think you can help my child and family?
- ◆ Have you helped other children and families like mine?
- ◆ What do you do best at meetings?
- ◆ Are you an advocate for children and families?
- ◆ What age children do you work with best?
- ◆ What is one thing you really like about my child or family?



# Advocacy & Communication

## *What is advocacy?*

Advocacy is helping people get the services they need and giving them support along the way. Advocacy is teaching and advising.



## *What do advocates do?*

Advocates help in many ways. An advocate might help you get ready for meetings, go to 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 the System of Care, each family usually chooses one person to be their special 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 the System of Care.

## *How can I be an advocate for my child?*

You already 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?*

It's as easy as K A T: KNOW - ASK - TELL

### **KNOW**

- ◆ Know your rights.
- ◆ Know the special education laws.
- ◆ Know your roles.
- ◆ Know what the System of Care can do to help.

### **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. Good communication helps you tell others your ideas and feelings. Good communication skills give you power and control.

### ***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. 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.
- ◆ Get your records in order.
- ◆ Talk to someone to find out how the meeting will be run.
- ◆ Bring an advocate if you need help.

#### 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, you should be polite.

#### Talk about issues, not people

A good rule is to say nothing personal. There may be people you don't like or trust, but you should not attack them. Stick to the issues. Talk about things that can be changed.

#### *Example*

*Say: "This kind of help is not working for my child."*

*Not: "You are a BAD teacher."*

## ***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 problem. 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 right 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 people or their ideas.

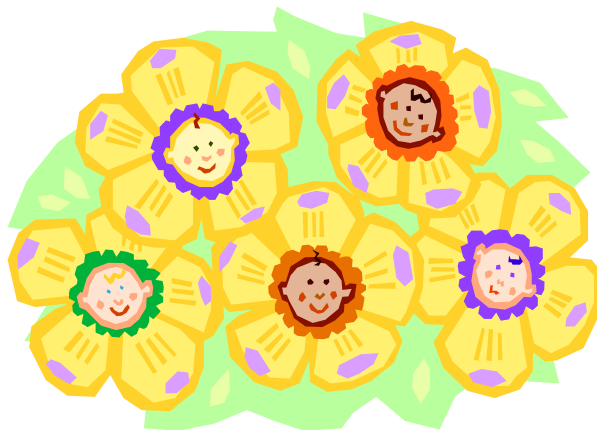
## ***Do I have to get "tough" to be assertive?***

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 some 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 you tell others what is going on or what you want, and 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:

- ◆ Date you are writing the letter
- ◆ Your name and address (phone number if you ask someone to call you)
- ◆ Name and address of the person you are writing to
- ◆ Your child's name
- ◆ Information about the problem or issue
- ◆ 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 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 may have special needs. Please refer him for testing to find out if he can receive special education services or related services.

I would appreciate hearing from you within the next ten days. Please call me at (*phone number*) if you have any questions about my request.

Sincerely,

Your name

## ***Sample Letter Documenting a Phone Call***

Your Address  
City, State, Zip  
Date  
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 \_\_\_\_\_. As I said on the phone, I am concerned about \_\_\_\_\_. You feel that \_\_\_\_\_ will help. The \_\_\_\_\_ (mental health provider/court counselor/Social Services worker, etc.) has agreed to \_\_\_\_\_. I also said that I would \_\_\_\_\_.

Thank you for your time and help.  
Sincerely,  
Your name

## ***Sample Letter Asking for Information***

Your Address

City, State, Zip

Date

Name of Person

Job Title

Address

City, State, Zip

Dear Dr. \_\_\_\_\_:

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

I would like more information about my son's medication and its side effects. I would like written information that I can share with his teachers.

Please send information as soon as possible. Call me at home (*phone number*) if you have questions.

Sincerely,  
Your name

## ***Sample Letter Asking for School Services***

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 therapy*) for (*child's name*). (*Speech therapy*) is part of my child's IEP, but he has not had this service yet. Please let me know when his (*speech therapy*) will begin.

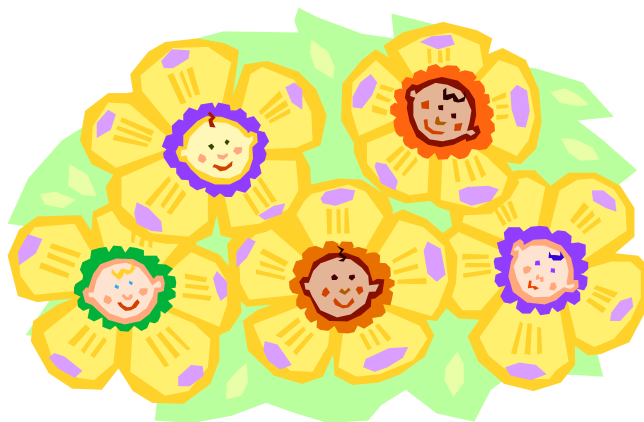
Without (*speech therapy*) my child is not receiving an "appropriate" education to meet his needs. The Community Medical Center will give my child (*speech therapy*) for \$50.00 an hour. If the school cannot give my child (*speech therapy*), I will take him to the medical center. Please send me the forms for billing the school for my child's services.

I hope to hear from you this week. It is best to call me at (*phone number*) before 8:00 a.m. or after 7:00 p.m. Thank you for your help.

Sincerely,  
Your name

Remember that it is very important to develop a file with important information about your child's care. This can help you and the child become excellent historians about previous services, and 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.

Also, remember that 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. IDEA - Individual Disabilities Education Act, which protects the rights of children with disabilities, and FAPE - Free and Appropriate Education Act guarantees that a child will receive a free public education. Along with IDEA and FAPE, a new law has taken effect, it is the No Child Left Behind law which is a Federal law regulating the education of children. There are many concerns surrounding this law. It is very important that you as a parent or caregiver learn what each of these laws say so you can provide a strong advocacy role for your child. A list of other Advocacy Organizations is provided later in this Handbook, along with how to find out more information about important laws. The Advocacy Organizations will be able to help you understand laws that protect your child's rights in school as well as other child serving organizations.



## Where we are in Developing System of Care in North Carolina

A System of Care for children and families in North Carolina is well on its way to moving from a dream to a reality. Within Mental Health Reform, the Children's Mental Health plan embraces the System of Care Model as a new way of doing business statewide.



Different child serving agencies are developing initiatives that adhere to the System of Care approach. Positive Behavior Interventions and Supports (PBIS) for the schools, judges training in SOC for Administrative Office of the Courts, SOC and Multiple Response System (MRS.) for the Department of Social Services; Community Based care for Youth Development Centers and Comprehensive Strategies for the Department of Juvenile Justice Delinquency and Crime Prevention, and School Based Mental Health Centers for Public Health. See the chart on the next page for more information about key reforms across North Carolina's child serving systems.

These reforms provide the ideal opportunity to use the System of Care framework to unify all these efforts across systems. According to the Administration for Children and Families (federal DHHS, 2005): "The System of Care approach was originally created to address the needs of children with serious emotional disturbances. This approach is based on the development of a strong infrastructure of interagency collaboration, individualized strengths-based care, cultural competence, child and family involvement, community-based services, and accountability. These principles are essential elements of any successful child and family service delivery system, including child welfare. The Systems of Care approach is now being used to address needs identified by States' CFSRs and improve outcomes for children and families involved with child welfare." (<http://nccanch.acf.hhs.gov/profess/systems/learn/outcomes.cfm>)

The foundation is laid and the work lies ahead. North Carolina's State Legislature has recently required System of Care approaches for children and their families. These laws are listed later in the Handbook. The State Collaborative for Children and Families continues to work to identify and resolve issues surrounding a seamless system of care. Come join us in the adventure as we make North Carolina a place where children and youth grow up in their homes, schools and communities. You can do this by attending your community's local Community Collaborative to learn more about how System of Care is being implemented in your community, share this handbook with others, and work as a partner with families and professionals in your community to build a strong and effective System of Care.

**MODEL SIMILARITIES ACROSS CHILD/FAMILY SERVING SYSTEMS  
AS PART OF SYSTEMS REFORM IN NORTH CAROLINA<sup>13</sup>**

	<b>EDUCATION: Positive Behavioral Supports</b>	<b>MENTAL HEALTH: Mental Health Reform</b>	<b>SOCIAL SERVICES: Multiple Response Systems</b>	<b>JUVENILE JUSTICE: The Comprehensive Strategy</b>
<b>Key Reform Models</b>	<p>Positive Behavior Support (PBS) is an application of a behaviorally based systems approach that enhances the capacity of schools, families, and communities to design effective environments that improve the link between research-validated practices and the environments in which teaching and learning occurs. Attention is focused on creating and sustaining primary (school-wide), secondary (classroom), and tertiary (individual) systems of support that improve behavior for all children and youth by making problem behavior less effective, efficient, and relevant, and desired behavior more functional.</p>	<p>The NC State Plan (2003, chapter 4 &amp; CMH Plan) requires a coordinated system of supports and services for children with behavioral and emotional disorders and their families to implement wraparound and family-centered approaches. This includes development of local broad-based, community-focused service systems with participation and contribution from a variety of public organizations, non-profit agencies, citizen stakeholders and parent and child advocacy organizations. The participation of all these partners is necessary to efficiently and effectively respond to mental health needs of children, in the context of their families, schools, and community. At the core of this system are the Child and Family Teams responsible for implementing and managing the family-centered wraparound plans.</p>	<p>The Multiple Response System is an effort to reform the entire continuum of child welfare in North Carolina, from intake through placement services. The reform is based upon the application of family centered principles of partnership through seven strategic components of MRS. MRS allows for more than one response to initial reports of child maltreatment.</p>	<p>The comprehensive strategy is based on the establishment of a continuum of juvenile delinquency prevention, early intervention, and graduated sanctions programs that are built on research, driven by data, and focused on outcomes. The continuum starts with prenatal prevention and includes community based prevention services based on a risk and resource assessment, immediate interventions, and a range of graduated sanctions that include institutional care and aftercare services. The prevention, early intervention, and graduated sanctions services and strategies are key points along the continuum and are designed to reduce and control the risk factors that contribute to delinquent behavior and ensure public safety</p>
<b>Principles of the Model</b>	<ul style="list-style-type: none"> <li>• Teach and encourage respectful, responsible behaviors.</li> <li>• Use data continuously to support decision-making.</li> <li>• Create an individualized, total school climate that supports staff and student behavior and encourages family engagement.</li> </ul>	<ul style="list-style-type: none"> <li>• Interagency Collaboration</li> <li>• Individualized Strengths-Based Care</li> <li>• Cultural Competence</li> <li>• Child and Family Involvement</li> <li>• Community-Based Services</li> <li>• Accountability</li> </ul>	<ul style="list-style-type: none"> <li>• Partnership is a process</li> <li>• Everyone has strengths</li> <li>• Everyone needs to be heard</li> <li>• Judgments can wait</li> <li>• Partners share power</li> <li>• Everyone desires respect</li> </ul>	<ul style="list-style-type: none"> <li>• Intervene immediately and effectively when delinquent behavior occurs</li> <li>• Support core social institutions</li> <li>• Promote delinquency prevention</li> <li>• Identify and control the small group of serious, violent, and chronic juvenile offenders</li> </ul>

***For more information on exciting initiatives in North Carolina 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](http://www.ncpublicschools.org) and information on Positive Behavior Supports go to [www.ncpublicschools.org/ec/behavioral/initiatives/postivebehavior/programs](http://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.dhhs.state.nc.us/dma/](http://www.dhhs.state.nc.us/dma/)
- ◆ 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](http://www.dhhs.state.nc.us/mhddsas) and click onto Child and Family [www.dhhs.state.nc.us/mhddsas/childandfamily/index](http://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.dhhs.state.nc.us/dss](http://www.dhhs.state.nc.us/dss)
- ◆ For more information about the Administrative Office of the Courts go to their Website: [www.nccourts.org](http://www.nccourts.org)
- ◆ For more information about the Division of Public Health go to their website: [www.ncpublichealth.com](http://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.ncdjjdp.org](http://www.ncdjjdp.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/>

- ◆ For more information on recent laws passed by the NC Legislature that promote System of Care approaches such as Child and Family Teams, you can review two important Session Laws passed in 2005:
  - the Comprehensive Treatment Services Program legislation can be viewed at: <http://www.ncleg.net/Sessions/2005/Bills/Senate/HTML/S622v9.html> (see Section 10.25.(b) on page 137)
  - the Collaboration Among Departments of Administration, Health and Human Services, Juvenile Justice and Delinquency Prevention, and Public Instruction on School-Based Child and Family Team Initiative legislation can be viewed at:  
<http://www.ncleg.net/Sessions/2005/Bills/Senate/HTML/S622v9.html> (see Section 6.24.(a) on page 34)
- ◆ For more information regarding Cumberland County Mental Health, the Consumer-Family Advisory Committee, or other aspects of local mental health services, see: <http://www.ccmentalhealth.org>

## ACRONYMS & TERMS

### A

AAMR - American Association on Mental Retardation  
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  
AHEC - Area Health Education Center  
AOC - Administrative Office of the Courts  
AMI - Alliance for the Mentally Ill  
ARC - Association for Retarded Citizens  
ASAM - American Society of Addictive Medicine



### B

BED - Behavioral/Emotional Disorder (public schools)

### C

CAP - Community Alternatives Program  
CAP- MR/DD - Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities  
CASSP - Child and Adolescent Service System Program  
CC - Community Collaborative  
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  
CJO - Criminal Justice Offender - Child or Adult Population  
CMH - Child Mental Health  
CMS - Centers for Medicare/Medicaid Services  
CSAT - Center for Substance Abuse Treatment

## D

DCD - Division of Child Development

DD - Developmental Disabilities

DHHS - Department of Health and Human Services

DJJDP - Department of Juvenile Justice and Delinquency Prevention

DMA - Division of Medical Assistance

DMH/DD/SA - Division of Mental Health, Developmental Disabilities,  
and Substance Abuse Services

DOC - Department of Correction (State)

DOH - Department of Health (County)

DPH - Department of Public Health

DPI - Department of Public Instruction (State)

DSDHH - Division of Services for the Deaf and Hard of Hearing (State)

DSM-IV - Diagnostic and Statistics Manual

DSS - Division of Social Services (State)

DWCH - Division of Women's and Children's Health (changed from Maternal and Child  
Health, 1997) (State)

DWI - Driving While Impaired

## E

EBD - Emotionally or Behaviorally Disturbed

EBP - Evidence Based Practice

ECAC - Exceptional Children's Assistance Center

ED - Emotionally Disturbed

ELT - Executive Leadership Team of the Division of MH/DD/SAS

EMH - Educable Mentally Handicapped (sometimes EMR -  
Educable Mentally Retarded)

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

FAPE - Free and Appropriate Public Education

FFCMH - Federation Families Children's Mental Health

FES - Family Empowerment Scale

FFK - Families for Kids

FSN - Family Support Network



## **G**

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**

ICC - Interagency Coordinating Council

ICD - International Classification of Diseases codes

ICF - Intermediate Care Facility

ICF-MR - Intermediate Care Facility - Mentally Retarded

IDEA - Individuals with Disabilities Education Act

IEP - Individualized Education Program

IFSP - Individual Family Services Plan

IPRS - Integrated Payment and Reporting System

IT - Information Technology

## **J**

JCAHO - Joint Commission for Accreditation of Healthcare Organizations

JCPC - Juvenile Crime Prevention Council

## **L**

LDA - Learning Disability Association (was ACLD)

LEA - Local Education Agency (Local Public School Systems)

LEP - Limited English Proficient

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



MED - Seriously Emotionally Disturbed - Child Population  
MHA/NC - Mental Health Association in North Carolina  
MHTF - Mental Health Trust Fund  
MMIS - Medicaid Management Information System  
MOA - Memorandum of Agreement  
MOU - Memorandum of Understanding  
MR - Mental Retardation

## N

NAMI-CAN - National Alliance for the Mentally Ill - Child Adolescent Network  
N.C. - North Carolina  
NCAMI - North Carolina Alliance for the Mentally Ill  
NCAMI-CAN - North Carolina Alliance for the Mentally Ill, Children & Adolescent Network  
NC Families United - 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

ODD - Oppositional Defiant Disorder  
OHI - Other Health Impaired  
OT - Occupational Therapy

## P

PCP - Person Centered Plan  
PEP - Personal Education Plan (Public Schools)  
PT - Physical Therapy  
PTO - Parent and Teachers Organization  
PTSD - Post Traumatic Stress Disorder  
PYFU - Powerful Youth Friends United (Powerful Youth)

## Q

QA - Quality Assurance  
QI - Quality Improvement  
QM - Quality Management



## **R**

- RFA - Request for application
- RFI - Request for information
- RFP - Request for Proposal
- RRC - Regional Resource Centers (Special Education)

## **S**

- SAD - Substance Abuse Disorder - Child
- SAMHSA - Substance Abuse and Mental health Services Administration
- 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
- SIS - Supports Intensity Scale
- SOC - System of Care
- SOS - State Operated Services
- SPMI - Sever and Persistent Mental Illness
- SS - Social Security
- SSI - Supplemental Security Income
- STR - Screening, Triage and Referral

## **T**

- TEACCH - Treatment and Education of Autistic and Related Communication Handicapped Children
- TMH - Trainable Mentally Handicapped (also TMR)
- TTY - Text Telephones

## **U**

- UM - Utilization Management

## **V**

- VI - Visually Impaired (also VH)
- VR - Vocational Rehabilitation



## W

WIC - Special Supplemental Food Program for Women, Infants, and Children



## WORDS TO KNOW

### **Access**

An array of treatments, services and supports is available: consumers know how and where to obtain them, and there are no system barriers or obstacles to getting what they need, when they need it.

### **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.

### **Adaptive Behavior**

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

### **Advance Directive**

A legal document that allows consumers 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, or being intercessor or defender.

### **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 treatment program.

### **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.

### **Anxiety Disorder**

Exaggerated or inappropriate responses to the perception of internal or external dangers.

## **Appeals Panel**

The 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**

All activities (tests, interviews, observations) to gather information leading up to writing a plan and identifying services or interventions that for a child and family.

## **Attachment Disorder**

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

## **Attention Deficit Disorder**

Symptoms are inattentiveness and impulsiveness. In some cases hyperactivity is also a symptom (ADHD).

## **Autism**

A developmental disorder that affects communication and behavior.

## **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 to reach 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 Handicapped (Public School)**

A handicap 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.

## **Case Management**

A service that helps individuals and families get and coordinate community resources such as health, behavioral health (mental health, substance abuse, etc.), income assistance, education, housing, and medical care.

## **Centers for Medicare and Medicaid Services (CMS)**

The federal agency responsible for overseeing the Medicare and Medicaid programs

## **Child and Family Plan (CFP)**

A comprehensive service and support plan for children with multiple and complex challenges and needs, and their families. The plan is based on family strengths, the goals and needs of the family. (Note: different agencies may have more specific plans related to their own mandates or funding requirements. See Person-Centered-Plan or Individual Education Plan for examples.)

## **Child and Family Team (CFT)**

A group of selected people that meets with a child and family to set goals and plan services. The CFT is built around the family to make sure the family's unique strengths are promoted and their needs are met. Team members, including the family, work together to write a Child and Family Plan that is based on what the family wants and needs.

## **Collaboration**

A helping relationship between a family member and a professional in which the family and professional share power and responsibility.

## **Community-Based Services**

The practice of having services as well as management and decision-making responsibility at the community level.



**Conduct Disorder**

Repetitive and persistent patterns of behavior that violate either the rights of others or age appropriate social norms or rules.

**Confidentiality**

Keeping information private. Allowing records or information to be seen or used only by those with legal rights or permission.

**Consent**

Giving approval or agreeing to something. For example, in education, a parent must give consent before a child can be evaluated or placed in a special program.

**Consumer and Family Advisory Committee (CFAC)**

A committee of ordinary people who get help from the LME or whose loved ones do. They advise the LME in the design of the local system.

**Cross-Categorical**

Special Education in which students receive services or are in the same classroom with students who have different types of disabilities.

**Cultural Competence**

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

**Developmental Disorders**

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

## **Dual Diagnosis**

A diagnosis of an emotional disorder and another disorder such as developmental delay, 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 Disorder (or Disability)**

Behavior, emotional, and/or social impairment exhibited by a child or adolescent that disrupts his/her academic and/or developmental progress, family, and/or interpersonal relationships.

## **End of Course Tests**

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**

Mental health, developmental disabilities, and/or substance abuse services that may be provided for those individuals meeting Target Population eligibility for services through NC Mental Health Reform.

## **Evaluation**

More in-depth than an assessment, examination of specific needs or problems by professionals using specific evaluation tools.



## **Evidence Based Practices**

Evidence Based Practice (EBP) refers to growing scientific knowledge about treatment practices and their impact on children with emotional or behavioral challenges. Defined by the Institute of Medicine (IOM) as "the integration of best research with clinical expertise and patient values".

## **Exceptional Children (public schools)**

All children who because of permanent or temporary mental, physical, or emotional handicaps need special education and related services to get an appropriate education in the public schools.

## **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 Support**

Persons identified by the consumer as either family members or significant others who provide the necessary support 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 Support Program**

Programs available in the community that help children and their families so that children can remain in their homes, and all members of the family can live balanced, healthy lives.

## **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 protects people who change jobs, are self-employed, or who have pre-existing conditions. The Act aims to make sure that prospective or current service consumer are not discriminated against based on health status. Protects privacy of consumer health information.

## **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 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.

## **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.

## **Least Restrictive Environment**

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

## **Local Management Entity (LME)**

Formerly known as Area Mental Health, Developmental Disability, and Substance Abuse Authorities, these public entities oversee and manage all public mental health, developmental disability and substance abuse services through contracts and other arrangements with their local Provider Community (private organizations that deliver direct services). Required by NC Mental Health Reform.

## **Mainstreaming**

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

## **Mental Illness**

General term for severe emotional problems or psychiatric disorders of adults.

## **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)

## **Objectives**

See Behavioral Objectives.

## **Person-Centered-Plan**

Individualized and comprehensive plan that specifies all services and supports to be delivered 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 nonclassroom 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 speech and language therapy, transportation, physical therapy, and counseling.

## **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 under Mental Health Reform.

## **Strengths Inventory**

A set of questions to help people think and talk about their strengths such as what they like to do and what they do well.

## **Support Services**

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

## **System of Care**

The process of different human service systems and community supports working together with families to provide a coordinated continuum of care driven by values and principles of the System of Care model.

## **System of Care Model**

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.

## **Target Populations**

Those individuals who meet eligibility requirements to receive Enhanced Benefits (see Enhanced Benefits definition) for mental health, developmental disabilities, or substance abuse conditions according to the NC State Plan for Mental Health Reform. In general, individuals who meet Target Population eligibility are those with the most serious or severe unmet challenges and needs.

## **Title I DPI**

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 DPI**

Title III is 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 DPI**

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**

The change from using children's services to using adult services, moving from one program to another, starting or leaving school, or other important life changes.

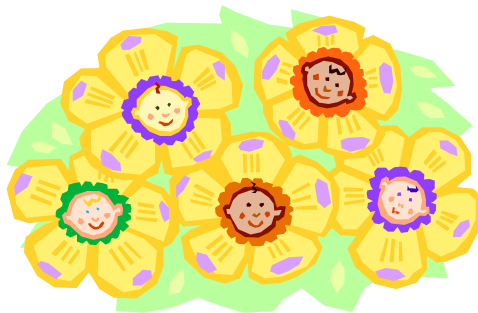
### **Wraparound**

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.

### **504 Plan**

A 504 plan is a legal document falling under the provisions of the Rehabilitation Act of 1973. It is designed to plan a program of instructional services to assist students with special needs who are in a regular education setting. 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.

**(Some of the information in this glossary is taken from the text of *Taking Charge*.)**





## Trauma Information Pamphlet

### For Parents

© 2001, Trauma Psychiatry Program  
University of California, Los Angeles

**Traumatic events** cause terror, intense fear, horror, helplessness, and physical stress reactions (for example, heart beating fast, strong startle, stomach dropping, shakiness). The impact of these events does not simply go away when they are over. Instead, traumatic events are profound experiences that change the way children, adolescents and adults see themselves and their world.

### Common Psychological Effects of Traumatic Experiences

- ◆ Many individuals who have had traumatic experiences suffer from ongoing reactions to them. These reactions are called **Posttraumatic Stress Reactions**. These reactions are common, understandable, and expectable, but are nevertheless serious and can lead to many difficulties in daily life.

There are three types of posttraumatic stress reactions.

***Intrusive reactions*** are ways in which the traumatic experience comes back to mind. These reactions include distressing thoughts or images of the event (for example, picturing what one saw) that can occur while one is either awake or dreaming. Intrusive reactions also include upsetting emotional or physical reactions to reminders of the experience. Some people may act like one of their worst experiences is happening all over again. This is called "a flashback" and can occur in response to a traumatic reminder.

***Avoidance and withdrawal reactions*** are ways people use to keep away from, or protect against, intrusive reactions. They include efforts to avoid talking, thinking and having feelings about the traumatic event and to avoid any reminders of the event, including places and people connected to what happened. Emotions can become restricted, even numb, to protect against distressing emotional reactions to thoughts or reminders of what happened. Feelings of detachment and estrangement from others may lead to social withdrawal. There may be a loss of interest in usually pleasurable activities.

***Physical arousal reactions*** are physical changes that make the body react as if danger is still present. These reactions include constantly being "on the lookout" for danger, startling easily or being jumpy, irritability or outbursts of anger, difficulty falling or staying asleep, and difficulty concentrating or paying attention.

- ◆ Trauma survivors also may suffer many types of losses - of loved ones, of home, possessions, and their community. The loss of important things often leads to **Grief Reactions**, which may include: feelings of sadness, anger, guilt or regret over the loss, missing or longing for the deceased, and dreams of seeing the

person or possession again. These reactions are normal, vary from person to person, and can last for many years after the loss. Although they may be painful to experience, especially at first, grief reactions are healthy reactions to loss, and reflect the ongoing significance of the loss. Over time, grief reactions tend to include more pleasant thoughts and activities, such as positive reminiscing about the lost person or possession, or finding positive ways to memorialize or remember them.

- ◆ Many people have endured both trauma **and** loss. More specifically, people who have suffered the **sudden** or **traumatic loss** of a loved one often find grieving the loss more difficult. The person may become preoccupied with memories of the disturbing circumstances of the death, such as its tragic and sudden nature, or with issues of human accountability (for example, in regard to building construction practices). This preoccupation can lead to **Complicated Bereavement**. Complicated bereavement is often characterized by intrusion of disturbing images of a traumatic death into **positive remembering** and **reminiscing**. This interferes with important ways of grieving that allow survivors to accept and adjust to the loss of a loved one. Complicated bereavement is also characterized by the avoidance of positive activities or relationships because they remind one of the traumatic loss. Due to its influence in constricting activities, complicated bereavement may interfere with normal life activities and normal child and adult development.
- ◆ An additional major concern for safeguarding the mental health of trauma survivors is the risk for **Depression**. Depression is different from posttraumatic stress, and carries its own risks. Its symptoms include: persistent depressed or irritable mood, loss of appetite, difficulty concentrating, greatly diminished interest or pleasure in life activities, fatigue or loss of energy, feelings of worthlessness or guilt, feelings of hopelessness, and sometimes thoughts about suicide.
- ◆ In addition to the psychological reactions described above, trauma survivors may experience **Physical Symptoms**, even in the absence of an underlying physical illness. These symptoms include headaches, stomachaches, rapid heart beating, tightness in the chest, appetite problems, and bowel problems (e.g., constipation and diarrhea). Physical symptoms often accompany posttraumatic, grief, and depressive reactions. More generally, they may signal elevated levels of life stress.

### Consequences of These Reactions

Posttraumatic stress, grief, and depressive reactions can be extremely distressing, and may significantly interfere with daily activities. Intrusive memories of past traumatic experiences can interfere in serious ways with learning, school and occupational performance, causing unexplained interruptions in concentration and attention. Avoidance of reminders can lead adolescents to place restrictions on their current activities, relationships, interests, thoughts, and plans for the future. Irritability and reactions to reminders can interfere with getting along with family members and friends. It is particularly difficult when family members have been together during a traumatic experience, because afterwards they can serve as traumatic reminders to each other, leading to unrecognized disturbances in family relationships. Problems with sleeping, concentration and attention can especially interfere with academic or occupational function and performance. People may respond to a sense of emotional numbness or estrangement by using alcohol or drugs. They may engage in reckless behavior and self-endangering actions. Adolescents may rely too much on their adolescent group for deciding about risk-taking behavior and have trouble in turning toward parents for counseling about risks and dangers. They may become inconsistent in their

behavior, as they respond to reminders with withdrawal and avoidance or overly aggressive behavior.

Depressive reactions can become quite serious, leading to a major decline in school or occupational performance and learning, social isolation, loss of interest in normal activities, self-medication with alcohol or drugs, acting-out behavior to try to mask their depression, and, most seriously, attempts at suicide. Complicated bereavement can lead to inability to mourn, to reminisce and remember, to fear a similar fate or sudden loss of loved ones, and to difficulties in establishing or maintaining new relationships. Adolescents may respond to traumatic losses by trying to become too self-sufficient and independent from parents and other adults, or by becoming more dependent and taking less initiative.

### **What Makes These Reactions Worse?**

**Posttraumatic Stress Reactions** are often evoked by **trauma reminders**. Many people continue to encounter places, people, sights, sounds, smells, and inner feelings that remind them of past traumatic experiences, even years afterwards. These reminders can bring on distressing mental images, thoughts, and emotional/physical reactions. Common examples include: sudden loud noises, destroyed buildings, the smell of fire, sirens of ambulances, locations where they experienced the trauma, seeing people with disabilities, funerals, anniversaries of the trauma, and television or radio news about the trauma.

**Grief reactions** are often evoked by **loss reminders**. Those who have lost loved ones continue to encounter situations and circumstances that remind them of the absence of the loved one, even years after the loss. These reminders can bring on feelings of sadness, emptiness in the survivor's life, and missing or longing for the loved one's presence. There are several types of loss reminders: **Empty situations** are ones in which the person is reminded of the absence of the loved one in his/her current life. These include: the empty place at the dinner table, activities that were once shared with the loved one, and special occasions like birthdays and holidays. Adolescents also are reminded by the everyday changes in their lives, especially hardships, as a **consequence of the loss**. Examples include decreases in family income, depression and grief reactions in other family members, disruptions in family functioning, increased family responsibilities, lost opportunities (for example, sports, education, other activities) and the loss of a sense of protection and security.

In addition to the distress evoked by **trauma** and **loss reminders**, **current trauma-related life adversities** constitute a significant source of distress. Efforts devoted to contending with these adversities may significantly deplete a person's coping and emotional resources, and in turn reduce or interfere with the ability to recover from posttraumatic stress, grief and depressive reactions.

### **How Can I Help?**

Parents can be very important in helping children and adolescents to recover from their trauma-related experiences and losses. Because children and adolescents go through many **normal** changes as they mature into young adults, it is not always easy to tell when they are bothered by posttraumatic, grief, or depressive reactions. It is also not always easy to know what type of support they need, or how to offer it. Here are some suggestions about ways to support your children, including open communication, emotional support, and practical support.



- ◆ Try to keep in mind what your children have experienced. Let your child know that you appreciate the seriousness of what they went through, and that you know that their reactions to their traumatic experiences and losses can continue for a long time. At the same time, try to reassure them that things will improve over time.
- ◆ Encourage your children to talk about ways in which they are still bothered by their experiences, losses and current difficulties. This will help you better understand their feelings and behavior.
- ◆ In speaking to your child, try to understand how they are feeling without being critical. For example, don't say things like, "Stop complaining," or "You should be over it by now."
- ◆ It is important to be patient and tolerant, especially when they talk repetitively about the trauma.
- ◆ Let them know how much you would like to be of help whenever they are reminded of their experiences or losses. Get familiar with the many ways your child may be reminded. It is helpful to be open about how you are still affected by reminders. As a family, you can then offer each other emotional support, through physical comfort, understanding and reassurance.
- ◆ Know that your children and adolescents notice and can be bothered by occasions when your mood changes suddenly or you act differently in response to a reminder. Let them know that you are reacting to a reminder and that it is not their fault.
- ◆ If your child feels guilty for the death or injury of others, reassure them that it was not their fault.
- ◆ Understand that anger is part of a child or adolescent's reaction to their post-trauma distress. Try to be tolerant and encourage them to talk about what is bothering them, rather than reprimanding them or telling them to be quiet. However, indicate that abusive language and violence is not allowed.

**Parents' responsiveness to their children's grief is important.**

- ◆ Allow your child to talk about a lost loved one, even though this may be upsetting to you. Don't try to stop them from feeling sad, as this is a normal part of grieving. If you think that their sadness is excessive, then seek psychological counseling.
- ◆ Try to help your children remember good things about a lost friend. Tell them positive things and stories that you remember about the person.
- ◆ When your children ask, don't be afraid to tell them that you are feeling sad when you are thinking about the loss of a loved one. On the other hand, try not to overwhelm your children with the responsibility of feeling like they have to take care of you.

Be open and tolerant of your child's protests over the unfairness of the loss and its impact on their lives. This will often resolve over time.

**Provided by the National Center for Child Traumatic Stress.**



## REFERENCES

1. Franz, John (1999). Paperboat.com
2. Family Support America (1997). "Making Room At The Table".
3. Early, T.J., Gregoire, T.K. & McDonald, T.P. (2002). Child functioning and caregiver well being in families of children with emotional disorders: A longitudinal analysis. Journal of Family Issues, 23, pp. 374-391.
4. President's New Freedom Commission (2002).
5. Burns, B.J. & Hoagwood, K. (2002). Community treatment for youth: evidence-based interventions for severe emotional and behavior disorders. New York, New York Oxford University Press.
6. Family Support America (1997) "Making Room At The Table".
7. Family Support America (1997) "Making Room At The Table".
8. VanDenBerg, J. & Grealish, M. (1999).
9. National Peer Technical Assistance Network Partnership for Children's Mental Health (1998) Family Professional Partnerships: Moving Forward Together, Available from: Federation of Families for Children's Mental Health, Alexandria, VA.
10. Evidence Based Practices - Beliefs, Definition, Suggestions for Families, ACMH, 2004.
11. Burns, B. J. & Hoagwood, K. (2002). Community treatment for youth - evidence-based interventions for severe emotional and behavioral disorders. New York, New York. Oxford University Press.
12. Evidence Based Practices - Beliefs, Definition, Suggestions for Families, ACMH, 2004.
13. Walker, J.S., Koroloff, N, Schutte, K. (2003). Implementing high-quality collaborative Individualized Service/Support Planning: Necessary conditions. Portland State University Research and Training Center of Family Support and Children's Mental Health.
14. Matrix of models table - Zechmann, M., 2005; adapted, Kaufman, MC, 2005

