Statewide Scan of System of Care in North Carolina
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Conducted for: North Carolina Collaborative for Children, Youth and Families

Conducted by: Addiction Consulting and Training Associates (ACT), LLC

ACT ADDICTION Consulting & Training ASSOCIATES

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Introduction

Much work has been done in the recent past to improve the services system for children who have physical, mental, social, emotional, educational, and developmental needs. Children and youth who have these needs present significant challenges for their families, the education system, court system, juvenile justice, social services, and medical and behavioral healthcare system. As part of this effort to improve services for children and youth, there have been initiatives to infuse System of Care (SOC) practices and principles in all child-serving systems. A SOC provides an evidence-based framework in which to provide services in a coordinated, integrated, and efficient way while focusing on the specific strengths, needs, and culture of the child/youth and family. Each child-serving system has its own mandates about the integration of SOC into practice and its own requirements for SOC training. The ongoing development of the SOC structure throughout North Carolina has been a significant improvement in how many of the public systems work together to insure coordinated care for children who have involvement across multiple systems. However, there is inconsistency in the number and quality of resources in counties and regions that creates disparity in access to appropriate levels and quality of care around the state. In keeping with SOC philosophy, it is important that child-serving agencies have a common understanding and implementation of SOC. In order to do so, it would be helpful to have a common set of standards by which to assess and evaluate the integration and implementation of SOC in communities and systems across NC and then develop a common plan for workforce development and accountability to ensure fidelity to the model of SOC and reduce duplication of efforts across systems.

Over the course of this project, a survey was developed and administered by which communities could be assessed and strengths and gaps identified so that local communities and statewide systems can take stock of available resources and focus on how to improve care within their communities, how to plan which services need to be present for the future, and how to strengthen and sustain SOC. The results of this community survey will hopefully become the framework that assists community partners in the development of effective interventions and strengthens the local service networks. The comprehensive analysis of the data collected through the survey will result in the following:

1. SOC processes and outcomes in each county and system
2. SOC expectations in each community and system,
3. Barriers in implementation,
4. Current funding streams for both implementation and training,
5. Mandated training components, and
6. Availability of current relevant training, as well as any other trends that present themselves.

In addition to the survey and an analysis of its results, there are several other components of this project.

- A thorough literature search was conducted across system areas (including family and youth organizations, child welfare, juvenile justice, mental health, education, substance use, developmental disabilities, and public health) which summarizes (1) the practices and processes which demonstrate the most effective outcomes for children; (2) the training practices focused on teaching and maintaining fidelity to System of Care; (3) a review of the most successful states' service arrays which have histories of effective outcomes; and (4) North Carolina-specific data from the systems identified above.
- All relevant reports specific to children involved across multiple systems were reviewed to identify the processes and child/adolescent characteristics present in North Carolina.
- A summary report was developed identifying the above characteristics of each community and system. The report uses information gathered in the literature search pertaining to state systems, effective evidence-based and evidence-informed practices,

and most effective service arrays compared to the data gathered specific to North Carolina.
- The report will also include a summary of the variety of funding used across SOC areas, as well as a summary of training available and accessed across SOC areas.

Identifying the sustainable practices, restructuring the existing training for practitioners and families, and understanding the funding streams available that support the SOC functions across communities are all necessary to insure refining the system and survival of the strong collaborations that exist for children and families. The factors listed below are significant changes on the immediate horizon that will have an impact on the existing SOC in North Carolina:

- Implementation of healthcare reform in 2014
- Identification of funding streams and training silos for SOC functions
- Move to streamline public systems (i.e., juvenile justice/AOC and mental health/developmental disabilities/substance abuse services)

The products produced by this project will inform and guide the Collaborative in ways that will insure services to children and families remain viable and strong in the future.

Literature Review

North Carolina has a long and rich tradition in System of Care (SOC) for youth and families. In 1979, the State led the nation with the creation of a SOC for a whole class of youth that had been denied appropriate treatment and were placed in institutional settings (Behar, 1988). The impetus for an integrated service model occurred as a result of a class action lawsuit against the state, Willie M., et al., vs. Governor James B. Hunt, Jr., et al. In the 1980s, the Robert Wood Johnson Foundation provided eight grants to communities across the country to develop systems of care. One of these grants was awarded to eleven western counties—Buncombe, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, Swain, and Transylvania—in North Carolina (Burns, et al., 1996).

In the 1990s, the Center for Mental Health Services awarded three SOC grants—the 1994 Pitt-Edgecombe-Nash Public Academic Liaisons (PEN PAL); the 1997 Families and Communities Equals Success (FACES in 2 central counties and 5 western counties)

- Guilford System of Care
- FACES in Cleveland County
- Families and Children Together (FACT) - Blue Ridge which included Buncombe, Madison, Mitchell and Yancey Counties
- Sandhills FACES- Anson, Hoke, Montgomery, Richmond and Randolph Counties

and the 1999 System of Care Network or SOC-Net in the counties of Halifax, Orange, Person, Chatham, Cherokee, Clay, Graham, Haywood, Jackson, Macon, and Swain. In the 2000s, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded four grants to the counties of Alamance, Bladen, and Mecklenburg (2004); Mecklenburg County (2005); Alamance County (2008); and Durham (2010).

In the 1990s, the State of North Carolina determined that SOC would be the working philosophy for care for North Carolina's children and created four entities to make it work: Child and Family Teams (CFTs); Care Review Teams; Community Collaboratives including the major child service sectors; and SOC Coordinators in each local management entity/ managing care organization (LME/MCO). Of note is the requirement of SAMHSA that their grantees incorporate evidence-based practices. This brief history

provides the background for examining the literature about achieving the most effective outcomes for (1) youth in SOC and (2) at the system level. More recent history addresses the process of implementing evidence-based practices in North Carolina SOC and across the nation.

Outcomes of Systems of Care

Systems of Care have been evaluated at national and state levels in select communities. Of initial interest is the ability of SOC to provide access to services. Table 1 provides a picture of the types of services utilized in the 12-24 month period of service and is quite similar to the first twelve months. The very high percentage of youth receiving individual therapy and case management is encouraging. The observation that more than three-fourths of youth were prescribed psychotic medication could be worrisome, but is fairly consistent with such a pattern for youth with serious emotional disorders placed in out-of-home settings. The fact that 30.5% of youth spent time in an inpatient or residential treatment setting and another 9.3% of youth in a group home or in treatment foster care may offer a partial explanation for the rate of prescribing (see Table 1 below, SAMHSA, 2010).

Table 1. Access and Service Use

Selected Services	12-24 mos.
Treatment	
Individual Therapy	89.8%
Case Management	83.9%
Medication	77.0%
Family Therapy	53.7%
Inpatient	16.4%
Residential Treatment Center	14.1%
Support	
Day Treatment	17.8%
Treatment Foster Care	4.8%
Group home	4.5%
Therapeutic Camp	4.1%

*(CMHI Sites Initially Funded in 2002-2006)

Important positive findings from the National Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program reported improved symptoms, decreased impairment, reduced arrests of youth, reduced caregiver strain, and fewer days missed at work by parents. These national findings were described in detail in a North Carolina report (O'Donnell, et al. 2012) on sustaining SOC in the State and are presented in Table 2 below (SAMHSA, 2010) and described briefly.

Table 2. Change in Symptoms Over One Year*

Outcomes	0-12 mos.	0-24 mos.
Improved behavioral and emotional symptoms	38.6%	48.7%
Decreased impairment	80.7%	63.7%
Arrest (> 11+ years; prev. 6 mos.)	17.5%	8.0%
Caregiver strain	36.2%	44.8%
Missed work (in days prev. 6 mos.)	6.2	2.8

*(CMHI Sites Initially Funded in 2002-2006)

Observations about changes from enrollment to twelve months reveal meaningful benefits of SOC participation. The most impressive findings are decreased youth impairment in functioning (80.7%) and improvement in behavioral and emotional symptoms (36.2%). During the 0-24 month period (with a reduced cohort due to successful termination, drop-out, or being placed out of home), results indicated a dramatically lower arrest rate for youth and half as many days parents missed from work, although caregiver strain was reported at a somewhat higher rate than during the 0-12 month period.

Encouraging outcomes have also been reported at the systems level. Foster (1998) found that children in a SOC received better and more timely follow-up services after being discharged from inpatient placements than similar children receiving traditional services at a different site. Also, from the national evaluation, costs savings have been estimated at $18 million for hospitalization and $6 million on juvenile arrests (SAMHSA, 2010).

Despite considerable success, ongoing challenges for SOC were also identified in the national evaluation. These include: (1) sustainability of SOC after termination of federal funding; (2) building a culturally and linguistically competent workforce; (3) establishing and maintaining meaningful cross-agency collaboration; and (4) continued use of restrictive services at a high level. Those concerning findings may also apply to SOC in North Carolina and need attention. Recent reports utilizing NC Medicaid data revealed patterns of significant time in restrictive placements, multiple placements into deep-end settings, and bouncing up and down the continuum of services resulting in a pattern of considerable residential instability for many youth (Hughes et al., 2011; Bruton et al., 2012). Such findings underscore the urgency for service providers and multiple service sectors to work together in an organized collective way.

Evidence-Based Practice

Evidence-based or evidence-informed practice (EBP) was unknown until after 1995. In fact, there were no references on EBP between 1900 and 1995, and then an explosion occurred. Effective mental health treatments, which have been tested in both controlled research trials and real world settings, are available for a wide range of diagnosed mental disorders (Burns et al., 1999; US DHHS, 1999; Nock et al., 2004).

Briefly, there has been solid evidence for the most common disorders. The cognitive behavioral therapies for anxiety, including trauma and depression, probably represented the longest research history for university-based development and recent provision in real-world service settings. To address disruptive behavior disorders, parent management training, family therapy, and home-based approaches have been prominent. Treatment for eating disorders, autism, and substance abuse have been progressing while for other less prevalent conditions (e.g., bipolar and Tourette's Syndrome), medication has tended to be the norm with a few notable exceptions (e.g., Fristad et al., 2003, with family and youth group

work). Evidence has been strong for selected supportive interventions (e.g., treatment foster care and wraparound) and has been emerging for peer interventions provided by parents and youth. Many interventions identified above have been implemented in NC SOC, consistent with the national registries, although most have been available in just a few agencies.

As the scientific basis for effective treatment became known to policymakers, providers, and families in recent years, significant adoption has been observed while SOC has continued to struggle with developing a continuum of care, creating inter-agency networks, and providing family-centered/family-driven care. Despite the ongoing challenges of SOC, the expectation that EBP will be incorporated is being mandated by policy, including reimbursement; professional organizations; increased efforts to train new practitioners in professional graduate programs; and critically, the Affordable Care Act as it is currently being implemented.

Implementing EBPs in North Carolina SOC and Nationally

The spread of EBPs in NC appears to be well underway in multiple child-serving systems, including an array of interventions for multiple mental health conditions and substance abuse in children and adolescents. In 2011, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, North Carolina Department of Health and Human Services (2012) conducted a provider survey and received reports from 74 agencies that offered child mental health EBP and 40 agencies that offered child substance abuse EBPs.

The child mental health EBPs are listed below by number of agencies offering each:

- Cognitive Behavioral Therapy (CBT) for depression 34
- CBT for trauma 29
- CBT for anxiety 28
- Dialectical Behavior Therapy 13
- Seeking Safety 11
- Child-Parent Psychotherapy 11
- Parent-Child Interaction 8
- Multi-Systemic Therapy 5
- Teaching Family Model 4
- Functional Family Therapy 3
- Incredible Years 2

The child substance abuse EBPs are likewise listed below:

- Motivational Interviewing 21
- Trauma-Focused CBT 15
- Seven Challenges 11
- Cannabis Youth Treatment 8
- Strengthening Families 5
- Adolescent Community Reinforcement Approach 3
- Family-Centered Therapy 3
- LifeSkills Training 3
- Brief Strategic Family Therapy 3
- Functional Family Therapy 2
- Multi-Systemic Therapy 1
- Towards No Drug Abuse 1

As the future potential of EBPs in SOC in North Carolina is under consideration, multiple questions require a response. Just what is an EBP and what opportunities does it offer to families and service systems? What resources are available for decision making, training, monitoring quality, and evaluating outcomes? What types of challenges will emerge?

To begin to address the first question, the Institute of Medicine (2001) defined EBP as "the integration of best research evidence with clinical expertise and patient values." Early resistance by clinicians was based largely on concerns about following a rigidly defined treatment protocol. In fact, the definition communicates a message of an interactive process between the client, scientific evidence, and the provider. Providers can include EBP in a treatment plan while still addressing individual differences in their clients. There is flexibility, and "the relationship" continues to be important. Expected benefits are better outcomes for children and families, also a value for service systems, in contrast to negative findings for most
"usual care."

The question about resources is significant. Beginning with decision making about which EBP a SOC would adopt is no small task. The informational resources available can be overwhelming, but also a strength, as the child service sectors are covered by multiple registries. The registries do include prevention interventions, specify age groups, and address diagnostic categories. There are more than 15 websites one could investigate, covering hundreds of interventions (see Appendix A), clearly way beyond the capacity for adoption by clinicians in SOC. Thus, careful selection is required.

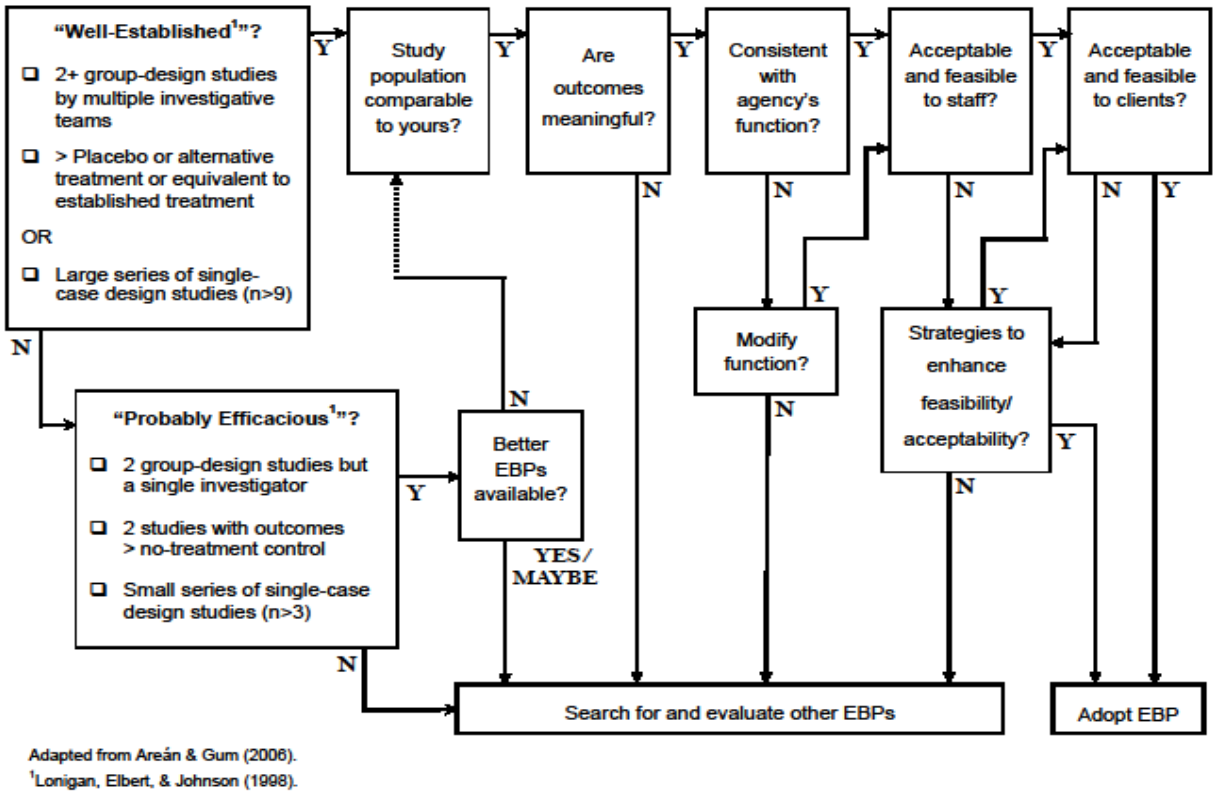
Not surprisingly, many interventions are listed in registries for multiple child-serving systems because a range of child mental health conditions occur across sectors. For example, juvenile justice is largely concerned with disruptive behavior disorders (DBD, including ADHD, oppositional disruptive disorder, and conduct disorder), and depression; child welfare with trauma, anxiety, and depression; schools with DBDs, anxiety, and depression in adolescents; and primary care with ADHD in young children and depression and substance abuse in adolescents.

A more efficient resource for intervention selection and decision making might come from the State of Virginia. Both wisely and clearly, what is provided in their document spells out by disorder "what works," "what seems to work," and "what does not work" (see excerpt in Appendix B). In addition, this useful report provides information on psychosocial and medication interventions, prevalence estimates, and solid descriptions of child and adolescent disorders (Virginia Commission on Youth, 2013).

Missing from the Virginia document are the supportive interventions which are not diagnosis specific but are very important for youth with serious emotional disturbance (SED). Those interventions are mostly evidence-based and include wraparound, treatment foster care, mentoring, peer interventions, and engagement strategies to keep youth and families in treatment.

Further, the decision-making process about the selection of which EBP to offer requires a true understanding of the clinical needs of the client population and buy-in from service organizations, providers, and families. Figure 1 below presents a model to engage in this process from a SAMHSA toolkit utilizing this approach applied to disruptive behavior disorders (SAMHSA, 2011).

Figure 1. Decision Making in Selection of Evidence-Based Practices



After selecting EBP candidates for the SOC or agency, the process involves exploration of the big questions on the top line of the model. See Appendix C for topics to explore by administration, clinicians, and families. Further, a simple and easily administered scale for assessing clinician readiness for EBP can be found in Appendix D (Aarons, 2004).

Resources for EBP training have increased dramatically in the past ten years. There are national organizations that train across the country in physical and behavioral health, schools, juvenile justice, and child welfare service systems. States have also developed training organizations. Supported by SAMHSA, the National Child Traumatic Stress Network (NCTSN) is both developing and disseminating trauma treatments and constitutes an important resource for training in the State. Affiliated with the NCTSN at Duke, the North Carolina Child Treatment Program (NC CTP) has trained over 500 clinicians in trauma interventions in NC and has plans to do much more as a result of a legislative mandate. Application of the "learning collaborative" model for quality implementation of an EBP is a special feature of national and NC initiatives. Developed by the Institute for Health Initiatives in Boston (Berwick, 2003), the approach has been successfully studied for multiple medical procedures and child mental health (Cavaleri et al., 2006). Basically, it involves team-based learning in communities of practice, which allows team members to learn from each other and to support ongoing learning using the Plan-Do-Study-Act (PDSA) process. For detailed information about applying the learning collaborative model to the implementation of evidence-based trauma treatment, see Ebert and colleagues (2012). NC SOC would benefit from this dissemination and implementation resource.

Quality and outcome monitoring represent further priorities as EBPs are being implemented. Data systems in this State do not capture either quality or outcome monitoring on a systematic basis and are necessary to ensure quality treatment and positive outcomes.

Challenges

Future challenges to implementation of EBPs in SOC are multiple and potentially foreboding. General themes include: (1) adequate resources for training; (2) an ability to fully implement EBP, and (3) the impact of child and family risk factors on successful participation in services. Training can be expensive, especially when provided by the developer, and typically requires a year to obtain enough consultation/coaching to fully implement the intervention in an agency. A risk of partial implementation, documented in a national survey of 616 service providers, found partially implemented EBP protocols due largely to a failure of agencies to mandate such and to widely ranging supports within agencies to do so (Walrath, et al., 2006). Experience in NC and other states have revealed multiple related barriers to successful implementation, including agencies that are reluctant to pay clinicians while they attend training (if clinicians are in training, they are not billing); need for coaching and supervision by supervisors trained in the EBP; training of administrators and supervisors; fidelity monitoring; booster training sessions; staff turnover; need to train new hires; and costs associated with the identified barriers.

Finally, the APA Task Force on Evidence-Based Practice for Children and Adolescents warned that "even when services are provided in the manner described, barriers to positive outcomes may exist, including chronic and severe psychopathology, parental psychological difficulties, needs of siblings, and familial inability to access or utilize services" (2008, p. 40).

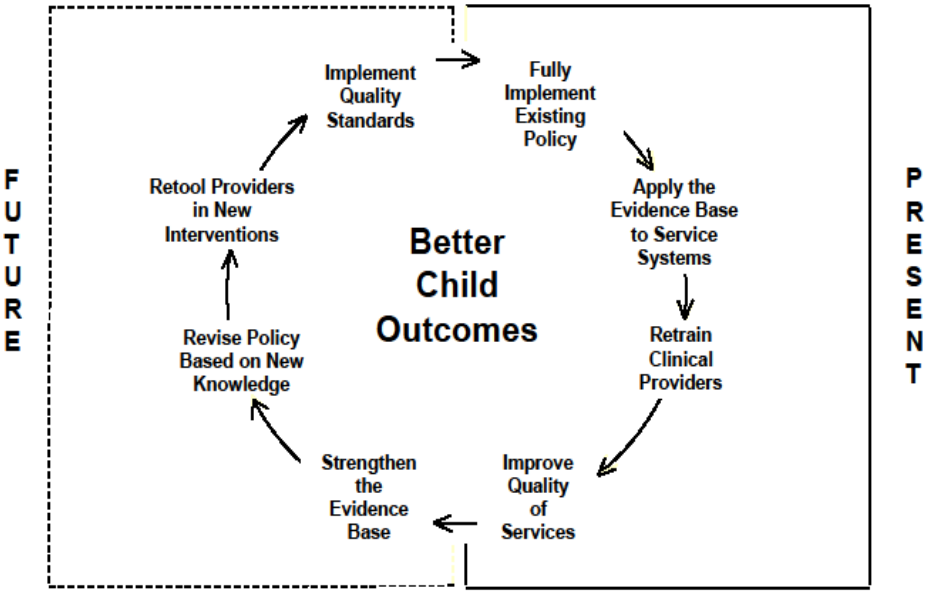
Summary of Literature Review and Future Implications

In conclusion, North Carolina has been a lead state in both designing innovative systems of care (for description of features, see Stroul & Friedman, 2011) and adopting EBPs. Variability across the state in SOC and EBP implementation is not fully known. This SWOT (i.e., strengths, weaknesses, opportunities, threats) analysis provides information about such critical factors as fiscal resources for training and implementation and the commitment of multiple agencies and families to the tenets of SOC.

For the future, implications based on the literature and prominent initial findings, include the following:

First, the simple model in Figure 2 communicates that inclusion of EBPs in SOC is an iterative process to implement the present knowledge base. The next sequence of phases will occur in the future as the science for child and adolescent treatment advances. Recognition that change is challenging now and will continue over a long time period suggests careful preparation.

Figure 2. A Strategic Model for Improving Outcomes



From: Burns, Hoagwood, & Maultsby (1998).

Second, there is a strong need to identify gaps in specific services in regions across the State based on community profiles.

Third, it is critical to find ways to incentivize full participation in EBPs by all child service sectors involved in the Community Collaboratives with county, state, federal, or other dollars.

Fourth, it is very important to continue engaging family organizations as they advocate for change and support in a period of fiscal reductions in services for youth.

Fifth, it is necessary to implement a data system which monitors service utilization and outcomes of care—a true value for youth, families, and clinicians to track progress, and data to educate legislators about the outcomes of services for youth with multiple needs.

One option could be to incorporate the Outcomes Referrals WellnessCheck Tool (Kraus, 2012; Outcomes Referrals, 2013). It has been validated in SOC across NC and includes features such as outcomes available for client viewing. It has been utilized widely by a range of provider organizations and is recommended by such organizations as the Annie E. Casey Foundation, Massachusetts Behavioral Health Partnership, and Mental Health Systems PC in Minnesota for dialectical behavior therapy.

Overview of Survey Methods

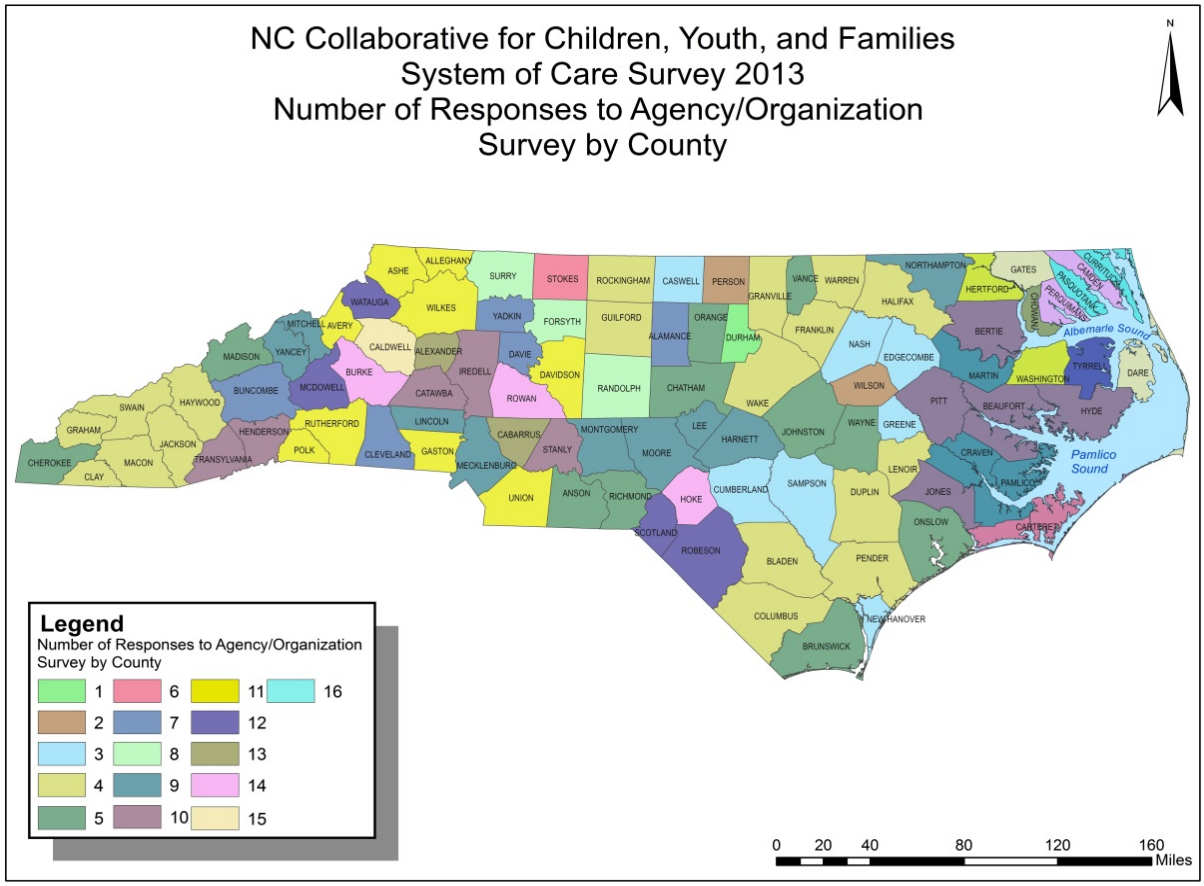
In order to collect responses for the survey, links were sent to the NC Collaborative for Children, Youth, and Families listserv and to the members of the Collaborative's Training and Technical Assistance Workgroup. Members were asked to widely distribute the survey to persons who they felt had good knowledge of SOC and to distribute it on their listservs. In addition, members of the Collaborative identified key stakeholders who should be included, and those persons were contacted individually. SOC coordinators were asked to encourage each local community collaborative to participate. Efforts were made to contact people in counties and systems that were not represented in the survey to ensure that all systems and all parts of the State were covered. For the final analysis, 19 responded to the organization survey at the state level; 251individuals responded to the organization survey at the county or regional level; and 59 individuals responded to the family and youth survey. A copy of each survey, including responses, is included in Appendix E, F, and G respectively.

Survey Results

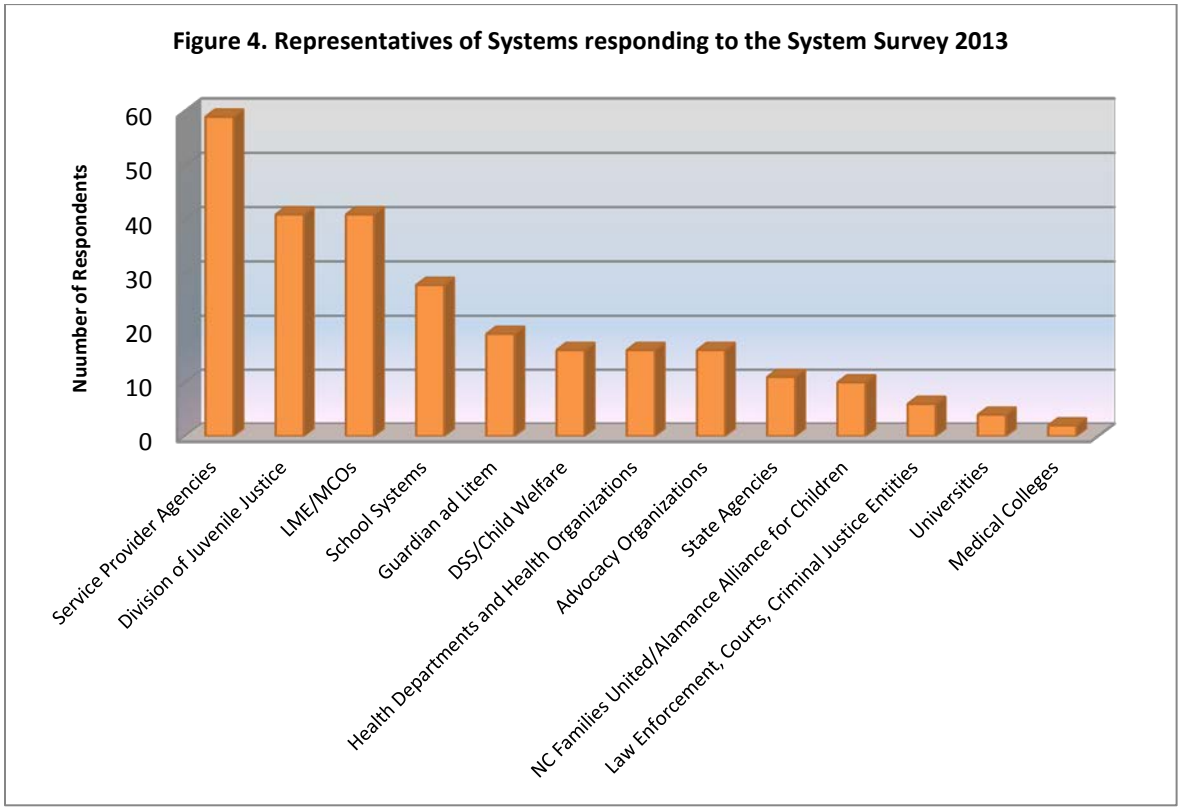
State Agency/Organization Survey

A total of 270 individuals responded to the agency/ organization survey. Figure 3 presents a map of the number of survey respondents in each county where SOCs were located. A full map is included in Appendix H.

Figure 3.



A detailed list of specific agencies, organizations, and state systems that participated in the survey process is located in the summaries of Appendices E and F. Figure 4 provides a visual depiction of the organizations that participated in the surveys. Provider agencies (59 respondents) lead the list, followed by LME-MCOs (41), the NC Division of Juvenile Justice (41), and county school systems (28).



For the analysis, data were categorized into state agencies and community-based organizations that serve one or more counties. Nineteen respondents stated that they serve the entire state. The remaining 251 respondents stated that they are involved in a single county-level SOC or two or more counties. In the paragraphs that follow, responses at the state level are presented first, then the responses for county-level SOCs.

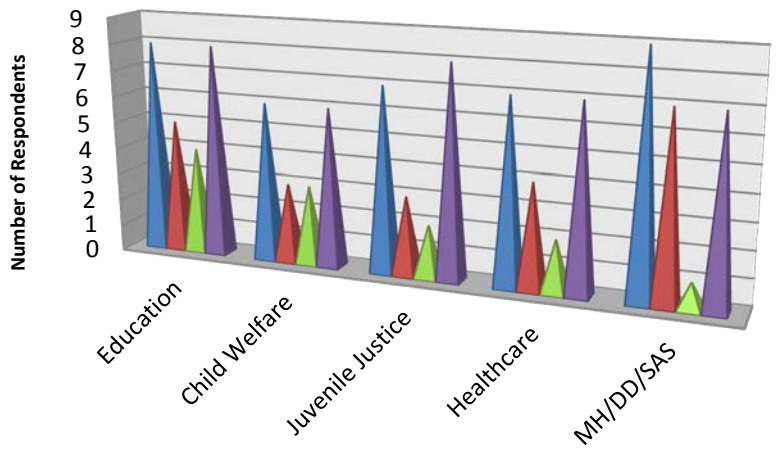
State-Level Responses to the Survey

At the state level, the following partners are involved in System of Care; the 19 respondents most frequently identified school systems, MCOs, and social services as being three systems involved in SOC.

- 18 School System
- 16 MH/DD/SAS LME-MCO
- 16 Social Services/Child Welfare
- 11 Youth
- 11 Family Organizations
- 11 Public Health
- 15 Families
- 12 Juvenile Justice
- 12 Service Provider Agencies
- 11 Community Care of NC
- 7 Youth Organization
- 2 Vocational Rehabilitation

About half the respondents stated that their agency had formalized the SOC relationship through an interagency agreement. Less than one quarter had co-location of staff. The responses are displayed in Figure 5 below.

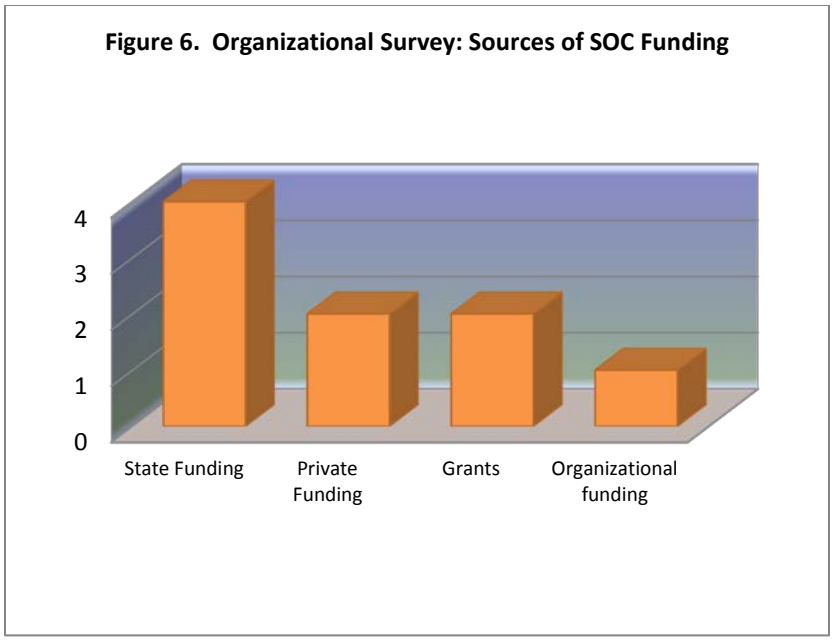
Figure 5. Formal and Informal Agency SOC Relationships between System Respondents 2013



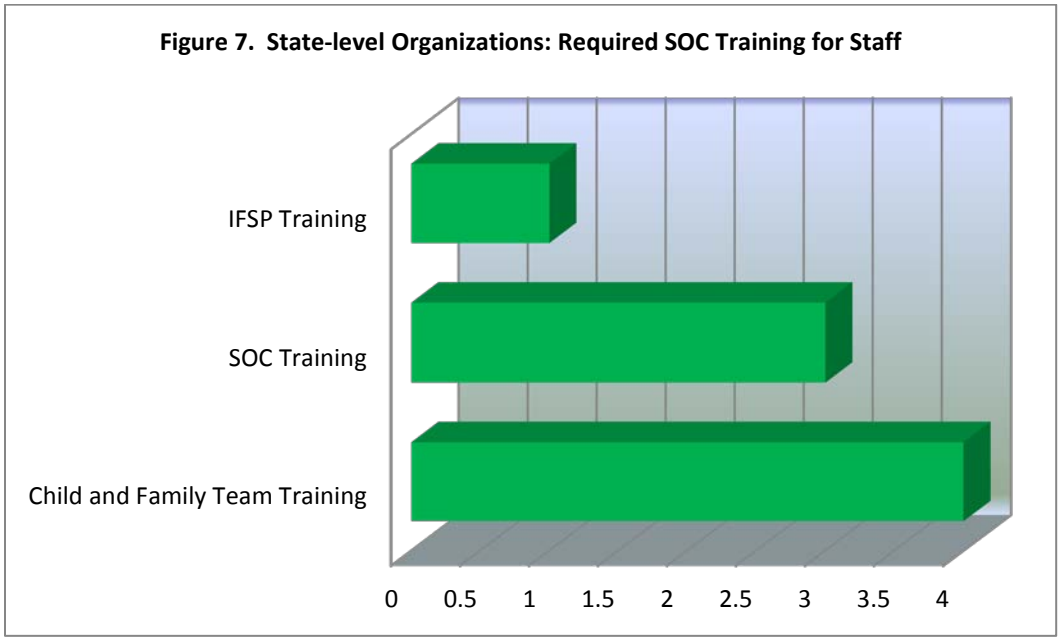
	Education	Child Welfare	Juvenile Justice	Healthcare	MH/DD/SAS
Interagency Agreement	8	6	7	7	9
Consultation Provided	5	3	3	4	7
Co-location of Staff	4	3	2	2	1
Information Access to Staff for Care Coordination	8	6	8	7	7

Respondents were asked to identify the primary function of the collaborative. Information sharing topped the list with 8 respondents. Three others discuss specific cases, 2 conduct strategic planning, 1 said that local providers meet to "discuss struggles", and 1 said that they discuss trends. Eleven respondents participate in Child and Family Team (CFT) meetings; 7 said that a representative from their organization regularly facilitates CFT meetings.

Sources of funding for SOC implementation include State funding, private funding, grants, and organizational funding. Figure 6 presents a graphic display of these funding streams.



Eight of 13 respondents said that their system requires SOC training. Figure 7 provides the types of mandated training.



(Please note that CFT courses fall under the rubric of SOC.)

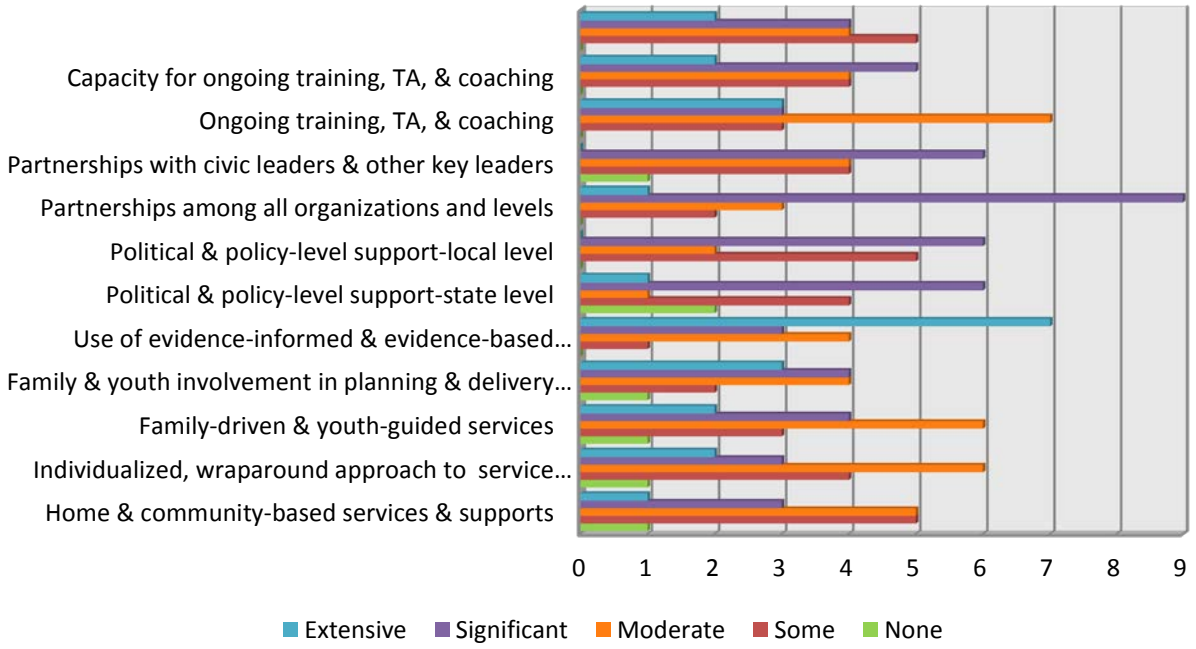
The average number of training hours was 11.4 hours, ranging from 8 to 18 hours. The target audience was primarily providers (6 respondents), CABHA and LME staff (1), everyone in the SOC (1), and teachers (1). Two noted that Family Partners are included in the training. Sources of funding for SOC training included state funds (3 respondents), grants (2), agency (2), private funding (1), and federal funding (1).

Twelve respondents said that their systems actively work to include families and youth in all levels of SOC (i.e., planning, training, and implementation). Families and youth are involved in CFT meetings (8 respondents), conduct trainings (3), participate in the implementation of specific projects (2), assist in policy development and review 1), participate in therapy sessions (1), and sit on committees statewide and locally (1).

Recruitment of families and youth for SOC involvement included the offering of training opportunities (2 respondents), the hiring of a training coordinator who supports recruitment and the development of family and youth partners (1), invitations to attend meetings (1), and relationships with contracted agencies (1). Five stated that they encourage families and youth to participate but did not identify specific recruitment strategies.

Figure 8 presents the progress that systems have made towards creating, expanding, or generating specific services and/or supports. Fifteen respondents gave the highest rating (mean of 4.1 on a 5-point rating scale) to the use of evidence-informed and evidence-based approaches, followed by partnerships with provider organizations, management in provider organizations, and MCOs (mean of 3.6), family and youth involvement (mean of 3.4), and ongoing training, technical assistance, and coaching (mean of 3.4). The least amount of progress was made in the area of home and community-based services and supports (mean of 2.9)

Figure 8. System Progress on Specific Services and Supports



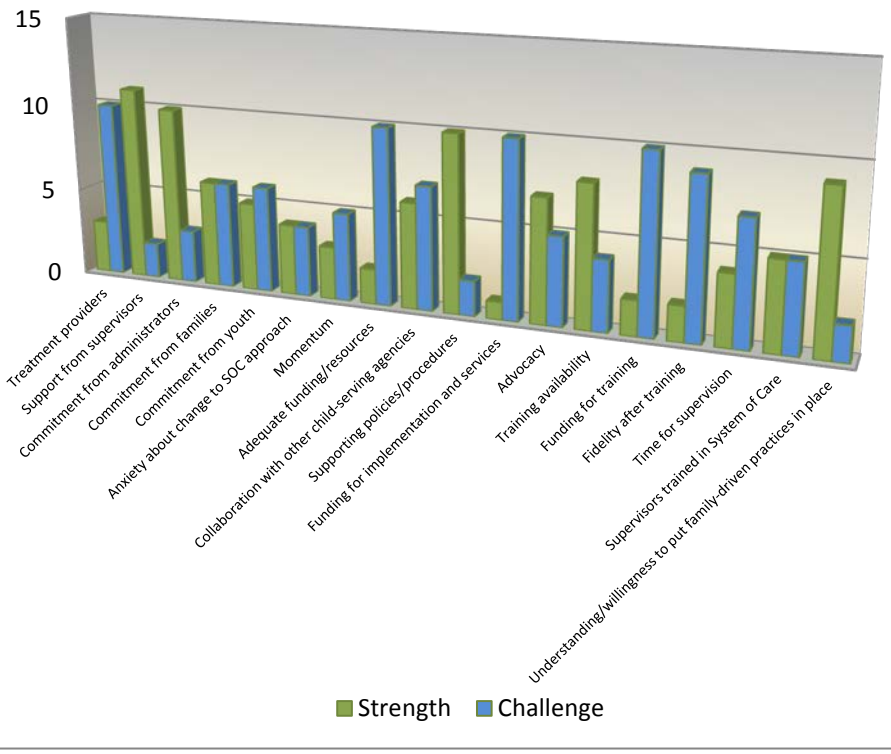
Only one respondent said their system has fidelity measures in place. Fidelity was in the form of bi-monthly conference calls with the evidence-based practice agency to ensure model fidelity.

Respondents were asked questions about training. Ten affirmed that their system's trainings were open to other members of the community and system partners. Five said that their system has an orientation to SOC for new employees/group members. Of these 5, 2 said that they have SOC training for new employees; 2 provided information on SOC; and 1 identified an online website, http://nccti.org. One

respondent each identified the following trainings as being beneficial to SOC implementation: CFT courses, trauma-informed training, Family Partner training, gang awareness, and trainings on family engagement. Other practices that have been beneficial to SOC implementation were the development of a policy requiring CFT for foster care entry, family case plan development, and quarterly review of case plan; and the offering of consultation on a case-by-case basis.

Figure 9 indicates whether respondents viewed specific SOC aspects as strengths/ supports or challenges/barriers to SOC implementation. The greatest strengths were support from supervisors (11 respondents), commitment from administrators (10), supporting policies/procedures (10), and understanding/willingness to put family-driven practices in place (9). Ten people each identified the greatest challenges as treatment providers; adequate funding/resources; funding for implementation and services; and funding for training.

Figure 9. Strengths/Challenges for SOC Implementation 2013



Respondents were asked to define System of Care; 10 of the 19 addressed this question. Common to the definitions offered were terms such as interagency collaboration (8 respondents), wraparound (7), community-based (5), and support (6).

Organization/Agency-Level Responses to the Survey

If you look at responses where the individual self-identified as being part of a SOC (n=251) and where agencies that served the entire state were not included, the ones most frequently identified as a partner included mental health (218 respondents), social services/child protection services (212), juvenile

justice (206), school systems (201), service provider agencies (190), families (180), and public health (159). Other categories ranged from a low of 54 responses (vocational rehabilitation) to a high of 105 (family organization).

Of the 251 respondents, 22 respondents identified only one county SOC with which they were involved: Catawba, Chowan, Currituck, Dare, Davidson, Gates, Halifax, Hertford, Hoke, Jackson, Johnston, Lenoir, Lincoln, Mitchell, Pasquotank, Pitt, Richmond, Rowan, Rutherford, Swain, Washington, and Yancey.

Twenty-nine counties had more than one respondent. The number of individuals who indicated that they worked with a single county totaled 104. For example, ten individuals said they worked with Alamance County alone.

- 10 Alamance
- 3 Alexander
- 2 Alleghany
- 5 Ashe
- 3 Brunswick
- 8 Buncombe
- 2 Burke
- 3 Cabarrus
- 7 Caldwell
- 3 Carteret

- 2 Clay
- 3 Cleveland
- 3 Cumberland
- 2 Davie
- 3 Durham
- 2 Gaston
- 2 Guilford
- 2 Hyde
- 4 McDowell
- 6 Mecklenburg

- 2 Moore
- 4 New Hanover
- 4 Robeson
- 2 Stanly
- 2 Surry
- 6 Union
- 2 Wake
- 5 Watauga
- 2 Wilkes

One hundred twenty-two respondents indicated that they work with SOC in two or more counties. For example, seven individuals listed Alamance County, but they also identified at least one additional county. In order to be included in this count, the county had to be specifically identified. For example, "eastern counties" or "western counties" were not included in the count; three respondents answered in this manner.

- 7 Alamance
- 13 Alexander
- 11 Alleghany
- 5 Anson
- 11 Ashe
- 11 Avery
- 10 Beaufort
- 10 Bertie
- 4 Bladen
- 5 Brunswick
- 7 Buncombe
- 14 Burke
- 13 Cabarrus
- 15 Caldwell
- 14 Camden
- 6 Carteret
- 4 Caswell
- 10 Catawba
- 5 Chatham
- 5 Cherokee
- 13 Chowan

- 4 Clay
- 7 Cleveland
- 4 Columbus
- 9 Craven
- 3 Cumberland
- 16 Currituck
- 15 Dare
- 11 Davidson
- 7 Davie
- 4 Duplin
- 1 Durham
- 3 Edgecombe
- 8 Forsyth
- 4 Franklin
- 11 Gaston
- 15 Gates
- 4 Graham
- 4 Granville
- 3 Greene
- 4 Guilford

- 4 Halifax
- 9 Harnett
- 4 Haywood
- 10 Henderson
- 11 Hertford
- 14 Hoke
- 10 Hyde
- 10 Iredell
- 4 Jackson
- 5 Johnston
- 10 Jones
- 9 Lee
- 4 Lenoir
- 9 Lincoln
- 4 Macon
- 5 Madison
- 9 Martin
- 12 McDowell
- 9 Mecklenburg
- 9 Mitchell
- 9 Montgomery

- 9 Moore
- 3 Nash
- 3 New Hanover
- 9 Northampton
- 5 Onslow
- 5 Orange
- 9 Pamlico
- 16 Pasquotank
- 4 Pender
- 14 Perquimans
- 2 Person
- 10 Pitt
- 11 Polk

- 8 Randolph
- 5 Richmond
- 12 Robeson
- 4 Rockingham
- 14 Rowan
- 11 Rutherford
- 3 Sampson
- 12 Scotland
- 10 Stanly
- 6 Stokes
- 8 Surry
- 4 Swain
- 10 Transylvania

- 12 Tyrrell
- 11 Union
- 5 Vance
- 4 Wake
- 4 Warren
- 11 Washington
- 12 Watauga
- 4 Wayne
- 11 Wilkes
- 2 Wilson
- 7 Yadkin
- 9 Yancey

Thus, respondents that identified one or more counties totaled 248 of the 270. Three respondents did not identify which counties they served but are included in the analysis as they stated that they served more than one county even though they did not specifically name them.

When respondents were asked the ages of children/youth that their organization/group represents, the majority, or 213, said that they serve children and youth from age 0 to 24. Thirty-six said that they serve all ages. Six stated that they serve ages 3, 4, or 5 to adult. The most commonly identified SOC partners were MCOs (218 respondents), social services (212), juvenile justice (206), school systems (201), service provider agencies (190), families (180), and public health (159). Partners listed the least frequently were youth (98), youth organizations (77), Community Care of North Carolina (73), and vocational rehabilitation (54). Respondents were asked to name formal or informal relationships with other child service sectors. Ninety-three respondents noted interagency agreements with Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS). Consultations were provides most frequently with education (99 respondents), MH/DD/SAS (99), and child welfare (89). Co-location of staff occurred most often with MH/DD/SAS (107). Informal access to staff for care coordination was about the same for MH/DD/SAS (114 respondents), education (101), child welfare (100), and juvenile justice (100). Table 3 presents these data.

Table 3. Formal and Informal Agency Relationships

	Interagency Agreement	Consultation Provided	Co-location of Staff	Informal Access to Staff for Care Coordination
Education	81	99	36	101
Child Welfare	75	89	19	100
Juvenile Justice	76	1	26	100
Health Care	49	71	20	76
MH/DD/SAS Disabilities	93	99	45	114
Don't know	77	78	107	73

Respondents said that their SOC involved either a single county (121 respondents) or representatives from multiple counties (122). Two hundred twenty said that their organization was an active member of the local community collaborative, which met either monthly (187 respondents), every

other month (5), quarterly (3), or weekly (2). Respondents considered the primary function of the local community collaborative to be one of the following:

- 67 Collaborate (6 respondents)/collaboration (14)/Collaborative (18)/partners (8)/collaborating (1)/building system relationships (5)/coordinate (15)
- 66 Sharing info (58)/communication (8)
- 39 Needs assessment (39)
- 38 Systems level work (38)
- 30 Resources (30)
- 21 Service development/improvement (21)
- 21 Care review (21)
- 20 Financial planning (1)/funding (19)
- 19 Public awareness/education (19)
- 16 System of Care (9)/SOC (7)
- 15 Children/family positive outcomes (15)
- 13 Service provision (13)
- 11 Networking (11)
- 10 Training (10)

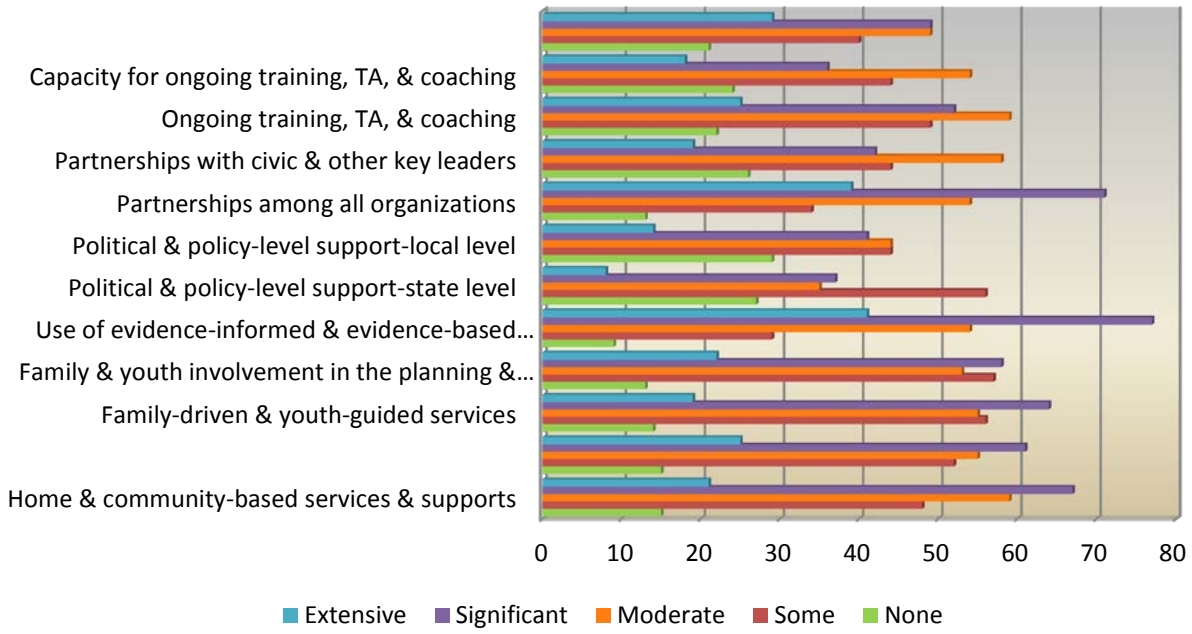
The majority (201 respondents) said that their organization regularly participates in CFT meetings, and about half (110) said that their organization regularly facilitates CFT meetings. For the 135 respondents that said that their organization does not regularly facilitate CFT meetings, they identified social services (33) and treatment providers (31) as being the agencies that typically facilitate these meetings. The most common sources of funding for SOC implementation include grants (38 (respondents), the State (24), and MCOs (19).

Eight-nine respondents said that their organization requires SOC training; 137 do not require it. Required training was most likely to be SOC, with 21 of the 52 respondents also mentioning CFT training. The mean number of required hours was 15.0 hours, ranging from 1.5 hours to 72 hours. The target audience was most likely to be providers (30 respondents), followed by families (18), the collaborative (13), and social workers (13). Forty said that they included Family Partners as a target group. Respondents identify MCOs (21 respondents), the State (15), federal grants (13), and the county (7) as sources of funding for SOC training.

Of the 251 respondents, 172 organizations actively work to include families and youth in all levels of System of Care (i.e., planning, training, and implementation); 52 do not. When families and youth are included, they are most likely to be invited to attend meetings or do attend meetings (104 respondents) and participate in the development of the treatment plan (51).

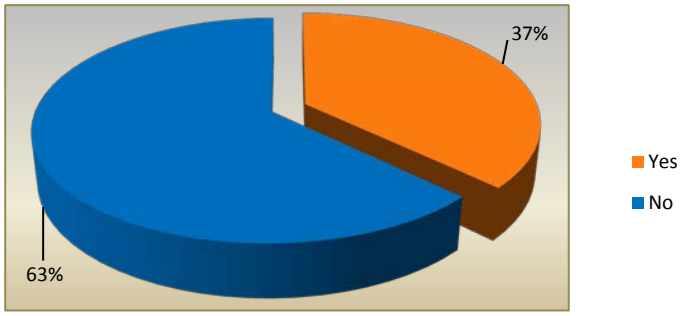
In terms of progress that their organization has made towards creating, expanding, or generating specific services and supports, the most progress has been made in the areas of the use of evidence-informed and evidence-based approaches (mean of 3.5 on a 5-point scale, where 1=none and 5=extensive) and partnerships with provider organizations, management in provider organizations, and MCOs (mean of 3.4). The least amount of progress was seen in the area of political and policy-level support at the local level (mean of 2.0). Figure 10 presents the data.

Figure 10. Organizations progress on Specific Services and Supports



When respondents were asked whether their organization/system has fidelity measures in place, 62 said yes and 105 said no. Figure 11 displays these data.

Figure 11. Organizations with Fidelity Measures in Place



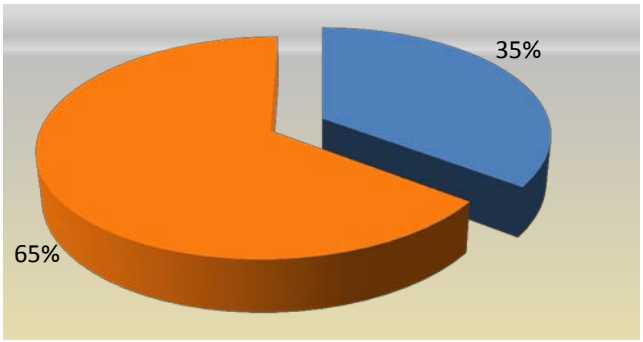
Fidelity measures included the following:

- 15 SOC implementation reporting and review, including goal/by-law review, MOA review, structured agenda review, and audit
- 10 Surveys, including consumer feedback, call centers, Wraparound Fidelity Assessment System (WFAS), Team Observation Measure (TOM), and Participant Rating Forms (completed at the end of Child and Family Teams by team members).
- 7 Care/chart reviews
- 7 Outcome measures, including child welfare data and child session documentation and progress reports
- 6 Quality assurance/utilization management/QI

- 4 Trainings
- 3 Corporate compliance, conflict of interest forms, and confidentiality agreements

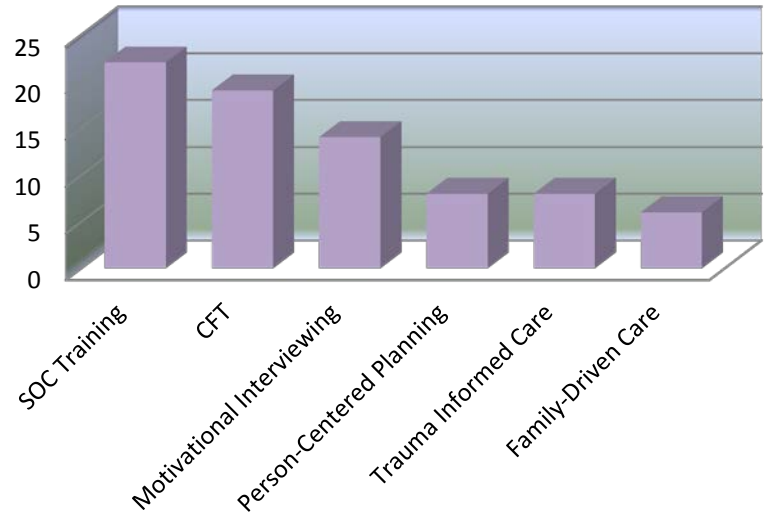
Respondents were asked whether organization-sponsored trainings were open to other members of the community and system partners. The majority, or 171, said yes, and 49 said no. Figure 12 shows that about one-third of the responding organizations (72 out of 205) has a SOC orientation for new employees.

Figure 12. Number of Organizations that offer an SOC orientation training to new employees



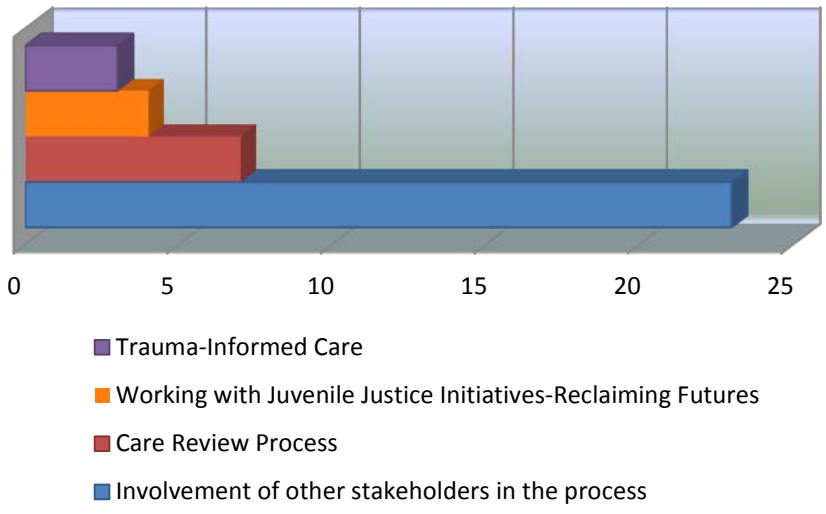
For those organizations with an orientation, 65 respondents stated that their agency conducts SOC orientation/training; this training varies widely by agency and ranges in duration from two hours to two days. Two others stated it was integrated in the two-week or four-week orientation offered by the hiring agency. The method of training varies from individualized to small groups in workshops and online or computer-based courses. Twenty-two respondents said that new employees/hires/volunteers are expected to take SOC training. Figure 13 indicates other trainings that respondents considered to be most beneficial to employees involved with SOC.

Figure 13. Trainings Listed as Most Beneficial to Employees



Of the clinical or system-building practices that have been beneficial to SOC implementation, respondents (23) most frequently identified the involvement of other stakeholders. Figure 14 illustrates these findings.

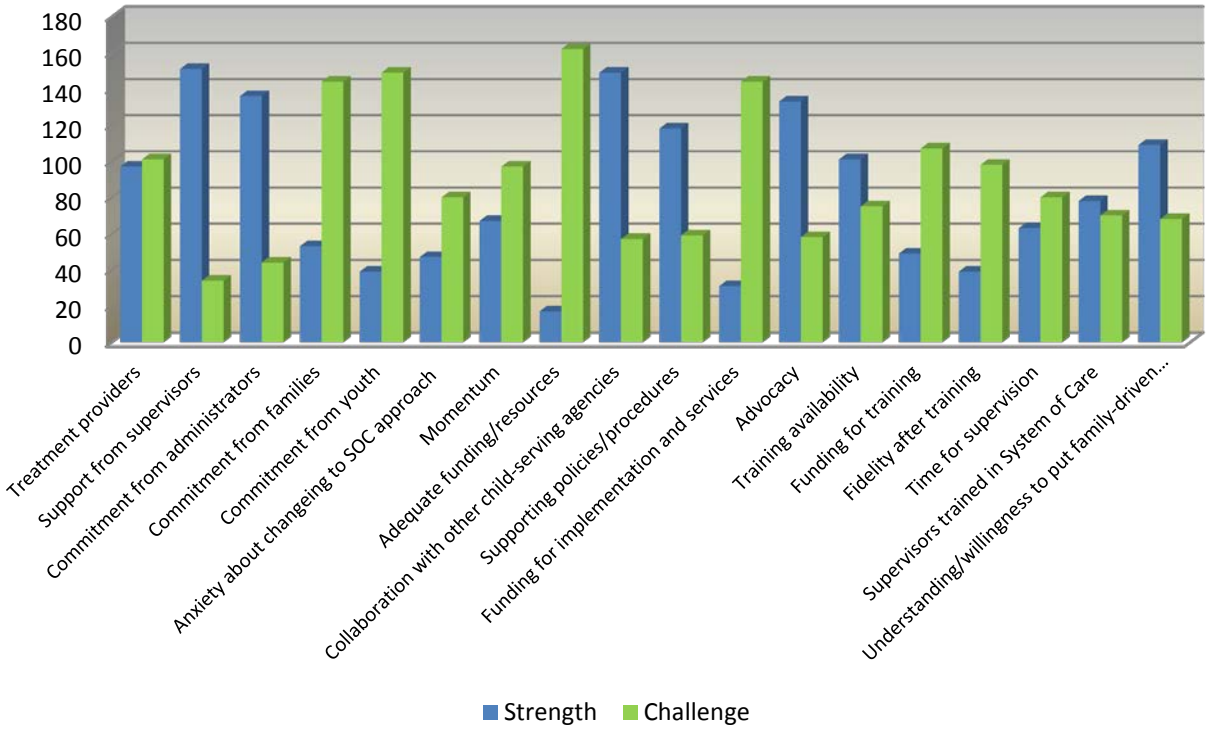
Figure 14. System-Building Practices Most Beneficial to SOC Implementation



Other practices include the care review process (7); working with juvenile justice initiatives, including Reclaiming Futures (4); and trauma-informed care (3).

Respondents were asked to list whether various aspects of SOC implementation have been strengths/supports or challenges/barriers. The strengths that were listed most frequently were support from supervisors (151 respondents); collaboration with other child-serving agencies (149); commitment from administrators (136); advocacy (133); supporting policies/procedures (118); understanding/willingness to put family-driven practices in place (109); and training availability (101). The challenges that were listed most frequently were adequate funding sources (162 respondents); commitment from youth (149); commitment from families (144); funding for implementation and services (144); funding for training (107); and treatment providers (101). Figure 15 presents these data.

Figure 15. Organizational Strengths and Challenges for SOC Implementation 2013



Sixty-three respondents identified additional strengths of SOC. Thirty-three noted the high level of collaboration among participating stakeholders. Other strengths included working together to improve SOC and its effectiveness (13 respondents); strengthening resources in the community (6); publicizing training and other opportunities (4); support from the community (3) and MCO (1); and inclusion of families and youth in the treatment process (3).

Respondents defined SOC in the following terms:

- 108 Collaboration
- 66 Services
- 58 Meeting needs of youth and family
- 48 Community based
- 33 Family driven/focused
- 32 Supports
- 18 Child centered/focused or youth guided
- 18 Resources
- 16 Strength based
- 11 Successful child/youth
- 11 Wraparound services
- 10 Culturally competent/sensitive
- 9 Access

The last question asked for additional comments about SOC. Forty-seven respondents offered comments, which fell into the following categories:

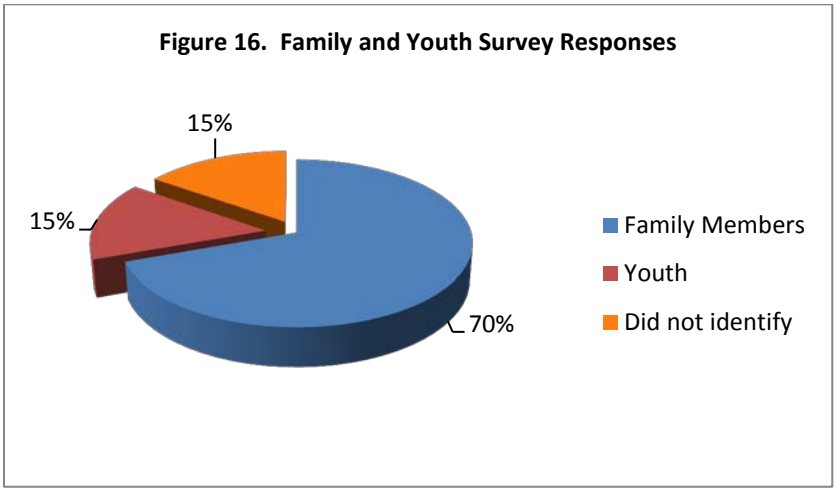
- 24 Positive comments about SOC
- 14 Made suggestions as to what SOC needs in order to work
- 9 Concern for the future of SOC due to implementation barriers
- 4 More info about SOC desired

The 24 respondents who offered positive comments about SOC were from nonprofits (8), county school systems (6), MCOs (4), universities (3), a collaborative (1), a county agency (1), and a state agency (1). However, even though respondents thought that SOC worked in their county, they had concerns about its future. One individual elaborated by saying, "It's great when it works but requires a very strong System of Care Coordinator, works best with the now non-existent work of case managers, fully inclusive participation by ALL parties involved with cases, and all parties understand that it takes time and may not be billable." Another said, "The system works when all parties do their part and support each other for the good of the families we serve." Yet another believed that SOC has great potential, but that his/her county fell short in key areas, "I think our community struggled with implementation fidelity. I believe there was limited buy in by provider administrators/mid-level supervisors, so there was not as much support, coaching, mentoring, and accountability processes to try to ensure that that working to implement SOC and wraparound did so with fidelity. When people 'get it' and implement it well, I think it has great potential. Unfortunately, I do not think it was realized in our community."

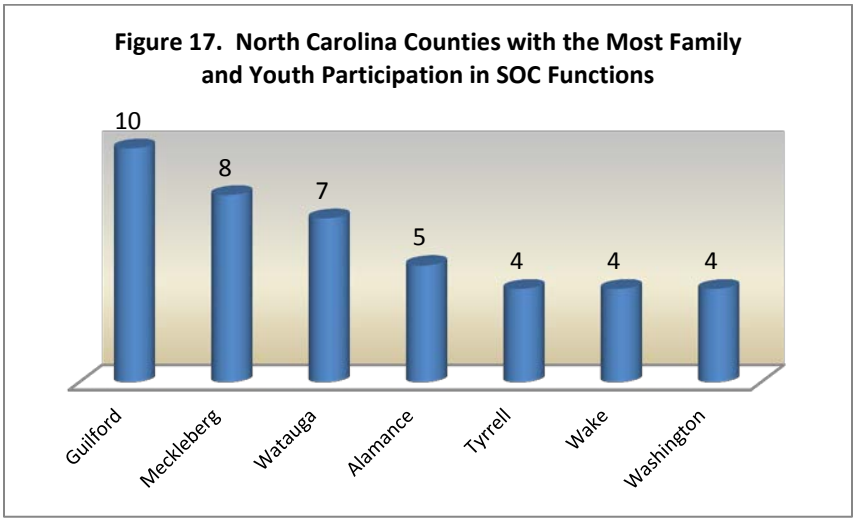
Family and Youth Survey

Of the 59 individuals who responded to the family and youth survey, 41 self-identified as family members, 9 self-identified as youth, and 9 did not say. Because of the low number of youth who completed the survey, their results are analyzed with those of family members. Figure 16 displays these results.

Figure 16. Family and Youth Survey Responses

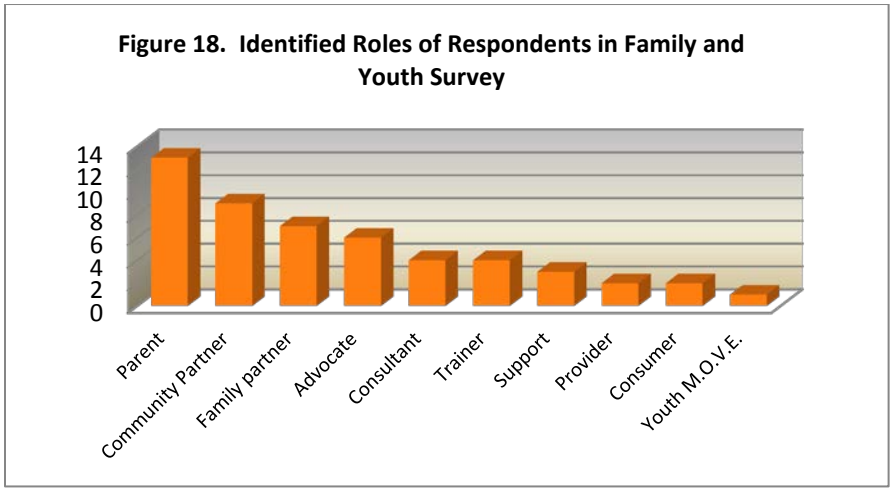


The mean number of years that the respondent's family had been involved in SOC was 6.9 years, ranging from 1 to 20 years. Counties with the most family members and youths participating in the SOC were Guilford (10 respondents), Mecklenburg (8), Watauga (7), Alamance (5), Tyrrell (4), Wake (4), and Washington (4). Figure 17 displays these data.



Of the 11 respondents who indicated that they were Family Partners, only four said that they worked in more than one county. Degree of involvement in SOC ranged from none (6 respondents) to extensive (18 respondents), with a mean of 3.4 on the 5-point scale.

Thirteen respondents self-identified as being a parent. Other roles included community partner (9 respondents), Family Partner (7), advocate (6), consultant (4), trainer (4), support (3), provider (2), consumer (2), and Youth M.O.V.E. (1). Figure 18 displays these results.



Personal accomplishments related to receiving specific services (e.g., IEP assistance) (7 respondents); providing training, services, or consultation (10); professional development (7); increasing personal awareness of services, understanding and insight related to child's needs, and skill building (9); and personal development (e.g., graduating from high school, enrolling in higher education, enhancing public speaking skills) (9). Respondents were involved with the following: families (31 respondents), LME/MCO (30), school system (30), family organization (25), youth (18), youth organization (18), service providers agencies (17), juvenile justice (16), social services/child welfare (14), public health (12), vocational rehabilitation (9), and Community Care of North Carolina (4). In addition, respondents identified whether or not they participated in specific SOC activities:

- 31 Local collaborative includes families and youth in SOC
- 29 Participation in local community collaborative
- 27 Attended SOC or CFT training
- 25 Participation in Child and Family Team (CFT) meetings
- 16 Facilitated SOC training
- 14 Participated in Family Partner 101 training

Of the 25 respondents who have been involved in CFT meetings, 21 said that they provide input into the time and place of these meetings. Family/youth involvement in SOC has included the following: participating in SOC trainings (5); giving input during the Child and Family Team meetings (5); providing consultation/advising/TA (5); assisting in SOC planning (4); participating in Youth MOVE (4); attending meetings (3); assisting in program development (2); participating in advocacy (2); and doing outreach (1) (some individuals identified more than one way that they had been involved; others didn't identify any). While most of the respondents to this question identified ways that they had been involved, several voiced their frustration, feeling that they were not given a part in decision making, that meetings were called only when they were convenient for staff, and the difficulty in finding individuals who would get actively involved in the collaborative. In terms of this last point, respondents were asked to describe methods of recruiting families and youth, and several said that it was very challenging and various strategies had been tried with little success. One mentioned that few families remained with the collaborative as they lost interest over time. Recruitment was viewed as an ongoing process and included community meetings and other activities (5 respondents); social media, public awareness campaigns including flyers (4); emails and listservs (3); trainings (1); inviting youth to meetings (2); invitation through provider agencies, schools, and community (1); personal testimonials (1); outreach (1); and word of mouth (1).

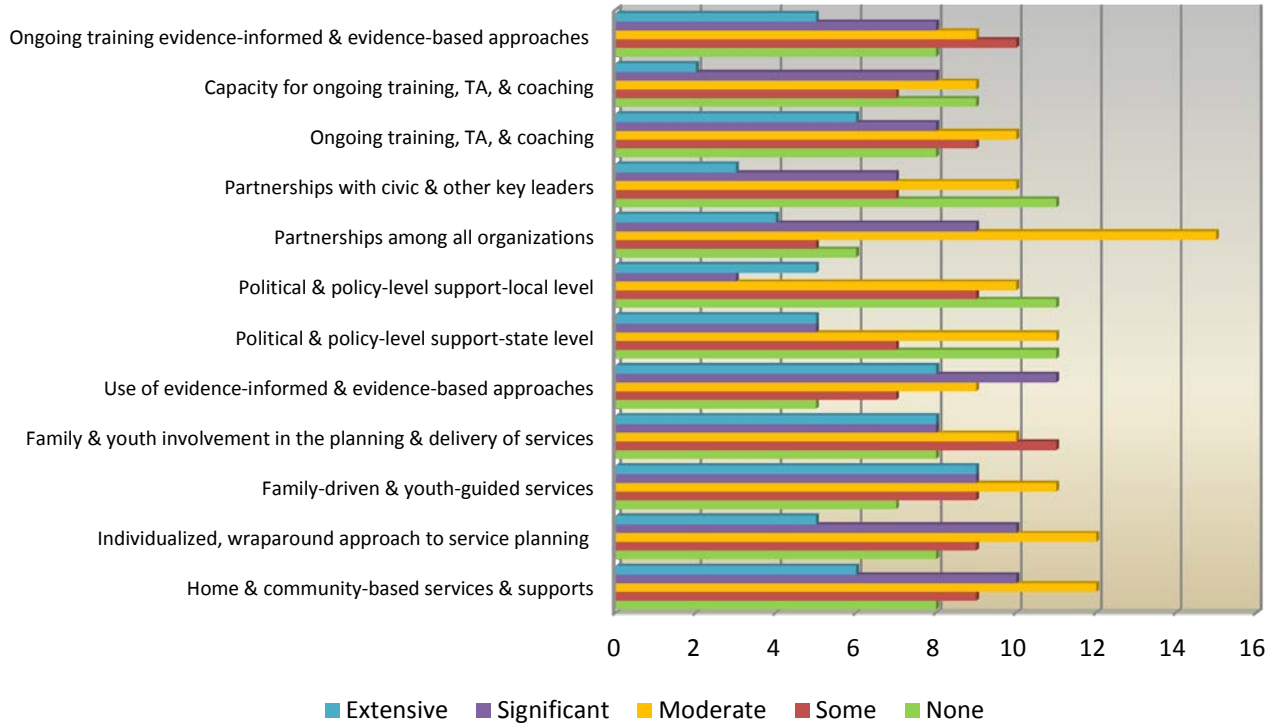
When respondents were asked how agencies and organizations could benefit from more family and youth involvement, one's comments aptly captured what others felt: "The information that the family and youth have is the 'real deal'…it is what is really happening in their homes. And, it is the feedback about services and supports. Having this information available along with both attending collaborative meetings, etc., keeps agencies and organizations keenly aware of what works and what does not. And, from the real life experiences, the collaboratives are so much richer in finding their direction on how to best serve family and youth." Another seconded this sentiment: "Each one of us has something to bring to the table, especially families and youth. They are the experts on themselves. Agencies could save time and sometimes money by empowering the family or youth to share whether an intervention will work for them or not. Families are asked, but it often feels like it is expected for them to comply with the suggestion on the table, so it does not feel like family choice." Several individuals felt that agency and provider staff "seem to always be busy with constant change and large numbers of consumers to treat"—this led to a feeling of powerlessness on the part of some of the respondents. Staff turnover was cited as a problem, which led to a lack of consistency for families. One said that "Most organizations tell the families what they need to do (to deserve the help) rather than wrap services around the family to help them succeed."

When respondents were asked for recruitment strategies for families and youth and for ways to help families and youth feel more comfortable, they suggested including the information as part of family orientation, providing trainings geared to youth and families, providing more information, promoting the organization, hosting public events, social networking, connecting with other community partners (e.g., athletic associations, churches), offering food and other incentives, and going to the places where youth are (e.g., schools, community events, LGBT rallies). It was clear that many felt frustrated with their encounters. The following comments are typical:

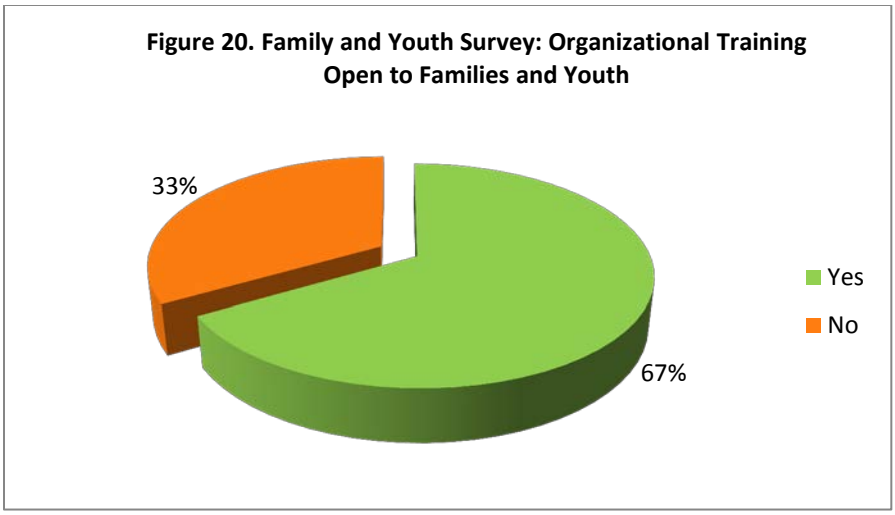
- Offer to help the families succeed rather than telling them what they need to do.
- Tell us that they exist.
- Act like they care for the child and their families. They have been told to treat families like robots.
- Time and location working for the family. Or, making transportation available.

Fifteen of the 52 individuals said that they work with a Family Partner. Four thought that the benefit of having a Family Partner on the team was significant; 10 considered the benefit to be extensive. Respondents were also asked to rate how much progress the SOC had made on numerous fronts. Figure 19 provides a summary of the data.

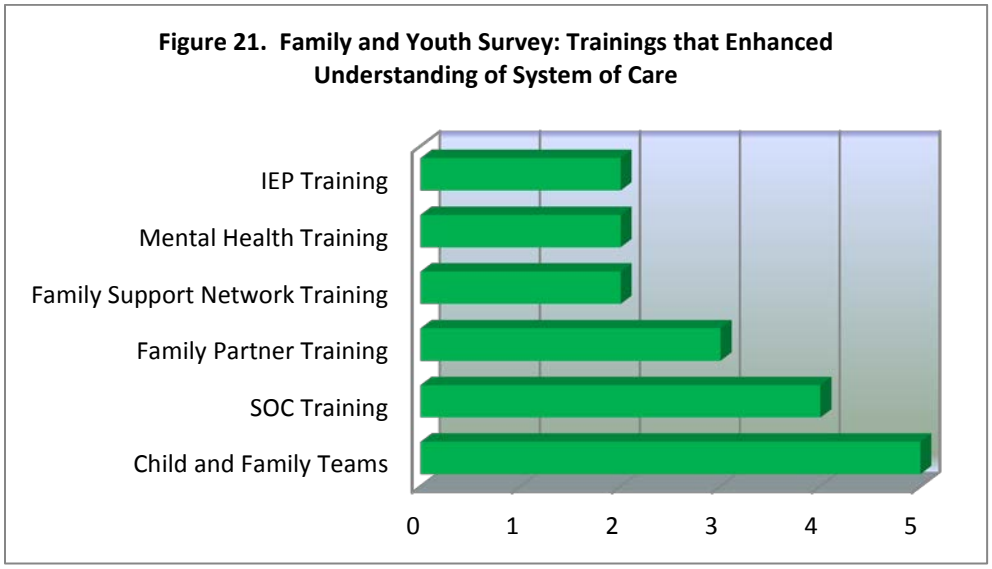
Figure 19. Family and Youth Survey Responds to System Progress on Services and Supports 2013



Respondents were asked about trainings offered by agencies; 28 said that the trainings were open to family members and youth while 14 said they were not. Figure 20 illustrates these findings.

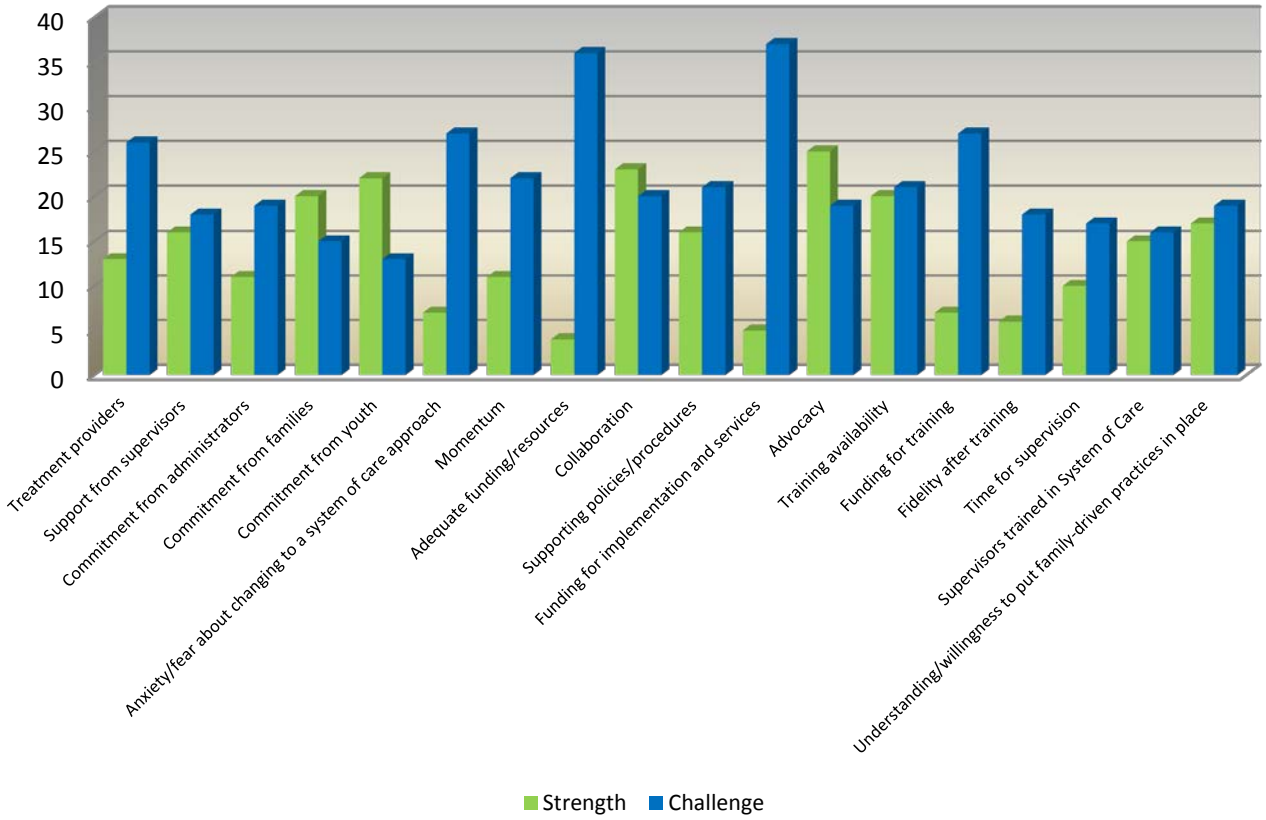


Training that enhanced family and youth understanding of SOC included Child and Family Teams (5 respondents); System of Care (4); Family Partner trainings (3); Family Support Network trainings (2); mental health (2); and IEP training (2). Other examples included Mental Health First Aid; W.R.A.P; Heart to Heart; RENEW and transition training; trauma and brain development; and leadership. Figure 21 presents these data.



Resource fairs and national SOC conferences were also noted as venues for training. Respondents identified the following as resources that were beneficial to their understanding or implementation of SOC: the community collaborative (3); NCFU (2); and working with specific individuals (2). Respondents were asked to identify specific aspects of SOC implementation as strengths or barriers; these are noted in Figure 22.

Figure 22. Family and Youth Survey Strengths and Challenges for SOC Implementation 2013



Respondents listed the following additional strengths of System of Care: collaboration (5 respondents); Youth MOVE (4); and trainings (2). Individuals noted additional strengths as SOC Coordinator, child family teams, mentor, family resource center, access to leadership, and RENEW.

When family and youth were asked to define the SOC, the most frequently recurring words were family (15 respondents), community (13), services (11), youth (9), support (9), collaboration (8), health (7), comprehensive/totality/all (6), together (5), network (4), and partner (3). These common terms are graphically displayed in Figure 23.

Figure 23. Families and Youth Survey: Word Block of Frequently Occurring SOC Terms

The last survey question allowed family members and youth to comment about SOC. Sixteen responded to the question. Responses fell within the following categories: worthwhile system that should be available to all areas (3 respondents); belief in concept of SOC (3); need for more education on SOC (3); SOC in relation to the respondent and how s/he and/or family was helped (2); implementation challenges that need to be addressed (2); changing the way agencies work together (1); need for more services (1); and being unable to understand all the survey questions (1).

Discussion

In general there was diverse representation from organizations across the State, especially providers (59 respondents), LME-MCOs (41), Division of Juvenile Justice (41), and school systems (28). Counties that have had SOC grant funding were also well represented, and one would assume that these counties have continued to have an active SOC, maintaining the model's core values and principles. If the number of respondents is an indicator, the SOC counties with the most respondents were Alamance (17), Buncombe (15), Mecklenburg (15), Pitt (11), Henderson (10), Transylvania (10), and Cleveland (9). What is surprising is the small number of respondents for Durham (4) as it is currently receiving grant funding from SAMHSA and has the reputation of being a strong SOC that has engaged multiple community partners.

Respondents were asked to identify the primary function of the local community collaborative. For those organizations serving single or multiple counties, collaboration was identified by 67 respondents and sharing information by 66 respondents. When asked to define SOC, 108 respondents from organizations identified collaboration as being part of the definition. These responses illustrated that these collaboratives involved multiple partners. Whether their organizations served the entire state or specific counties, respondents were alike in the types of stakeholders with which they partnered—the LME-MCOs, social services/child welfare, school systems, juvenile justice, service provider agencies,

and families. The majority also felt that their organization fielded staff that were active in their collaborative, whether they served the state, multiple counties, or a single county.

Using the SOC model as the framework for a discussion of the results, Stroul and Friedman (2011) define the core values of the SOC as being family-driven, youth-guided, and culturally and linguistically competent and the guiding principles as being child and family team based, individualized, strength based, and outcome based and data driven and having natural supports and collaboration at all levels of the system. When survey participants were asked to define System of Care, they used some of the same terms although not as often as one would think. While collaboration was identified by nearly half the respondents (108), only 66 respondents mentioned services provided, and only 58 respondents mentioned the value of meeting the needs of youth and family. Values and guiding principles—community based (48 respondents), family-driven (33), child-centered (18), strength based (16), and culturally competent (11)—were indicated much less frequently. With the exception of collaboration (23 respondents), family members and youth acknowledged slightly different strengths: advocacy (25), commitment from youth (22), commitment from families (20), and training availability (20). (Please note that only 9 youth participated in the survey so their responses are combined with family members.) In addition to the strengths listed on the survey, 63 respondents from organizations recognized additional strengths of SOC. Thirty-three noted the high level of collaboration among participating stakeholders. Other strengths included working together to improve SOC and its effectiveness (13 respondents); strengthening resources in the community (6); publicizing training and other opportunities (4); support from the community (3) and the MCO (1); and inclusion of families and youth in the treatment process (3). Family members and youth reiterated community collaboration (5 respondents) and identified youth leadership organizations (4) as additional strengths.

Training has historically been an integral component of SOC although challenges remain, such as adequate funding and staff time, as well as the need to train supervisors, the allocation of time committed to coaching and supervision, and the monitoring of implementation fidelity. Less than half (72 vs. 133 respondents) said that their organization requires an orientation to SOC for new employees/group members. One respondent noted the value of SOC and voiced concern about the future after grant funding ends. A similar finding was indicated for whether organizations mandated SOC training—89 respondents of the organization survey said that SOC training is required; 137 do not require it. Required training was most likely to be SOC, with 21 of the 52 respondents also mentioning CFT training.

Respondents from organizations rated the progress of offering ongoing training, technical assistance, and coaching as moderate (mean of 3.0). When asked if their organization had the capacity for ongoing training, technical assistance, and coaching, progress was considered to be moderate (mean of 2.9). Progress on creating ongoing training on evidence-informed and evidence-based interventions was also rated as moderate (mean of 3.1). State-level organizations gave higher ratings to progress in these three areas—ongoing training (mean of 3.4); capacity for ongoing training (mean of 3.3), and ongoing training for EBPs (mean of 3.2). Family members and youth saw progress most frequently in the areas of using evidence-informed and evidence-based approaches (mean of 3.3) and building partnerships with provider organizations, management in provider organizations, and MCOs (mean of 3.0). While the availability of training was viewed as a strength of SOC by both county and state-level SOCs (101+8), the majority considered funding for training (107+10) and fidelity after training (98+9) as challenges.

Sustainability was seen as a challenge across the board as evidenced by lack of adequate funding for SOC (162 community level respondents, 10 state level, and 36 family members/youth) and unsubstantial funding for implementation and services (144 community level, 10 state level, and 37 family members/youth). Funding affects the fidelity to which SOC is implemented—whether it is training, coaching, supervision, working with families and community partners on the treatment plan and its implementation, or monitoring/evaluating its implementation. One respondent noted, “Grant funding

has provided extensive supports that would not have been available otherwise and that has contributed to the strength and growth of our SOC." For those SOCs that currently do not have external funding, the only positions that are legislatively funded are the SOC coordinators at the MCOs. Funding is difficult to obtain as very few respondents were able to identify external sources of funding [i.e., grants (38 respondents), State (21), LME-MCOs (19), and county (11)].

Two noteworthy challenges were commitment from youth (149 community level respondents and 6 state level) and commitment from families (144 community level and 6 state level). These results are in contrast with what family members and youth indicated. Of the 56 respondents to the question about personal SOC involvement, 39 rated the degree of their involvement as moderate, significant, or extensive for a mean rating of 3.4 even though only 29 family members and youth said that they participated in their local community collaborative. Thirty-one of the 51 family member or youth respondents felt that community agencies actively involved them in planning, training, and implementation. The following two comments illustrate this involvement:

- We are involved with every decision and most of the time we are coordinating those decisions. Knowing how to get the services and the best help for their child to get home and have the tools to a better life.
- Decisions and input are always agreed upon by parents and team. Parents are always invited to have input and decision making. The power to change and make changes lies with them—we see ourselves as the support structure.

The experience of one family member prompted the following response: "Families should have to be recruited for involvement in System of Care; it should be an expectation of every family raising a youth with behavioral, emotional, and/or mental health needs that are multi-system involved that the systems will work collaboratively to assist the family in identifying their strengths, needs, and long-term goals and developing a family driven/youth guided, individualized plan for accomplishing their goals."

In contrast, other respondents expressed frustration with their SOC participation. For example, a youth stated, "Actually show an interest when we present to the state collaborative or the planning council. They look bored when we are speaking." One parent complained, "Many agencies don't tell their families about other organizations who foster family participation and certainly not family-run committees where opportunity to meet families who can advocate, advise, or guide them through System of Care." Another observed, "Often parents are asked to select the time they would like to have a meeting based on the choices presented to them. Usually those choices are what is most convenient for the agency staff."

Summary

To summarize the results of the family and youth survey, respondents overwhelming saw the value of involving families and youth in SOC. Whether respondents were speaking from the perspective of a family member/youth or from a community organization/agency, they agreed that SOC enriched the lives of participating youth through the development of family-driven, child-guided, and culturally competent treatment plans in cooperation with multiple stakeholders. It is hoped that the five local collaboratives to be identified in early 2014 will benefit from the experiences and expertise of the existing SOC. Essential components of an effective SOC are the active involvement of families, a strong SOC Coordinator, commitment from all community partners, and adequate funding. The following quote speaks to the critical role that families play:

"System of Care can only improve if families are the true leaders who influence the philosophy. They are the ones on the front line experiencing the struggles and success. There is no more important

voice in this process than those in the trenches. Some of our professionals in no way know what it feels like to actually live and breathe this journey each and every day. They have no idea what it feels like to be on this roller coaster and that you can't just get off. The professionals who have not dealt with a special needs child would never be able to build a better mouse trap without significant input from the families they attempt to service."

Important Future Issues to Consider

After reviewing the findings of the report, it would be prudent to develop a plan to pursue the topics identified in the report that need serious attention to further implement and sustain System of Care and to grow and sustain local community collaboratives throughout the state. The report had identified the following as issues for consideration:

- SOC is experiencing the same challenges today that is was facing in 2006. Today, there are fewer funding options for concepts like SOC and most likely it will be more difficult to sustain the SOC movement in the future. Consequently, there is a need for careful strategic planning for the SOC movement statewide that would include funding, training and long term support for local community collaboratives.
- An ideal role for the North Carolina Collaborative for Children, Youth and Families Training and Technical Assistance Workgroup would be to develop an education and marketing campaign to educate the system partners and community stakeholders about the successes of adopting, supporting and funding the current SOC efforts. Sustaining SOC at all levels in the system—state, regional and local agency level—requires buy-in at all levels and funding and support to use resources across all systems.
- There is a need for Local Community Collaboratives to take an active role in supporting the incorporation and use of evidence based practices at the local level. A potential way to accomplish this may be to pair the expertise of a stronger local community collaborative with ones that are struggling.
- As the Affordable Care Act becomes a reality and changes in the public service system evolve to explore mutual care management responsibilities, the role, support and funding for System of Care initiatives may need to be clarified, evaluated and increased.
- Valuing and promoting the partnership with families and youth is a basic tenant of the philosophy of System of Care. While the results are indicative of only those who answered the survey, it was apparent that the value and role that family members and youth play in participating in the SOC at the local level is significant. Their role helps to clarify and drive the appropriate design for care. The perception among involved family members and youth, however, is that professionals do not always recognize how vital the family member or youth voice is in the SOC process.
- Training in basic SOC philosophy and principles is not mandated by over half of the local agencies implementing System of Care. It is vital to the SOC movement that adequate time, attention and funding be given to training new professionals, as well as families and youth new to system of care, on the basics of SOC principles and how a vibrant System of Care can make a difference in the lives of people reliant upon social services for assistance.

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The North Carolina Collaborative for Children, Youth and Families Training and Technical Assistance Workgroup contracted with Addiction Consulting and Training Associates (ACT) in 2012 to conduct a state-wide community scan assessing the strengths and gaps of local communities as well as statewide systems in order to take stock of available resources, and focus on how to improve care within the communities, how to project which services are needed for the future, and how to strengthen and sustain System of Care.

The dedication to families and family driven practices that North Carolina Collaborative for Children, Youth and Families Training and Technical Assistance Workgroup have exhibited through the years has contributed greatly to the spread of the System of Care model throughout the state. In particular, for this project, the work and guidance of the Training and Technical Assistance Workgroup played a significant role in developing the vision and the approach for this project.

Addiction Consulting and Training Associates (ACT), LLC is a North Carolina based business that has developed an expertise in working with public sector organizations on issues relevant to underserved populations, in particular those with substance abuse, addiction and mental health conditions. Our business goal is to create the capacity for positive change in organizations that specialize in serving the public sector.

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ACT ADDICTION Consulting & Training ASSOCIATES

Appendices

A. Matrix of Registries
B. Excerpt from Virginia Commission Report (2013)
C. Topics to explore by administration, clinicians and families
D. Evidence-based Practice Attitude Scale (Aarons, 2004)
E. Organization survey and summary for state level respondents (19 respondents)
F. Organization survey and summary for county-level respondents (251 respondents)
G. Family and Youth survey and summary (59 respondents)
H. Map of North Carolina County Respondents

Appendix A

Registries and Clearinghouses

- Blueprints for Healthy Youth Development (http://www.blueprintsprograms.com/) (focus on evidence-based, cost effective programs that promote youth behavior, education, emotional well-being, health, and positive relationships)
- Blueprints for Violence Prevention (http://www.colorado.edu/cspv/blueprints/)
- California Evidence Based Clearinghouse for Child Welfare (http://www.cebc4cw.org/)
- California Healthy Kids Resource Center (http://www.californiahealthykids.org/index) (focus on health education topics, including media literacy)
- The Campbell Collaboration (http://www.campbellcollaboration.org/) (international in scope, with a focus on justice, welfare, and education)
- Child Trends (http://www.childtrends.org/index.cfm) (research to improve children's lives including topics such as child welfare, early child development, fatherhood and parenting, and indicators of child well-being)
- The Cochrane Collaboration (http://www.cochrane.org/) (international in scope, with a focus on health)
- Find Youth Info (http://findyouthinfo.gov/) (federal site that provides resources on topics such as substance abuse, mental health, juvenile justice, teen dating violence, runaway and homeless youth, bullying, and transition age youth)
- Home Visiting Evidence of Effectiveness or HomVEE (http://homvee.acf.hhs.gov/programs.aspx) (HRSA and ACF site that lists home visiting program models along with evidence of effectiveness)
- Institute of Education Sciences, What Works Clearinghouse (http://ies.ed.gov/ncee/wwc/default.aspx) (review of educational programs, products, practices, and policies to provide educators with information to make evidence-based decisions)
- Institute for Research, Education and Training in Addictions (IRETA), National Institute on Drug Abuse (www.ireta.org/NIDAblendinginitiative) (presents EBPs on substance abuse)
- National Implementation Research Network (http://nirn.fpg.unc.edu/) (to close the gap between science and service by improving the science and practice of implementation in relation to evidence-based programs and practices
- National Institute on Drug Abuse (http://www.drugabuse.gov/publications/preventing-drug-abuse-among-children-adolescents/chapter-4-examples-research-based-drug-abuse-prevention-program) (research-based drug abuse prevention programs)
- National Registry of Evidence-based Programs and Practices (http://www.nrepp.samhsa.gov/)
- Office of Juvenile Justice and Delinquency Prevention Model Programs Guide (MPG) (http://www.ojjdp.gov/mpg/)
- Promising Practices Network, Rand Corporation (http://www.promisingpractices.net/)

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- Suicide Prevention Resource Center Best Practices Registry (http://www.sprc.org/bpr)
- UCLA Center for Mental Health in Schools Clearinghouse: http://smhp.psych.ucla.edu/clearing.htm
- What Works Clearinghouse: http://whatworkshelpdesk.edu

Appendix B

From: Virginia Commission on Youth (2013). Collection of Evidence-based Practices for Children and Adolescents with Mental Health Treatment Needs, 5th Edition (pp. 23-32). Richmond, VA: Commonwealth of Virginia.

Reference Chart of

Disorders and Evidence-based Practices

Findings by Treatment Type for Children and Adolescents

Please refer to individual sections of the Collection for discussion of a particular disorder.

Adjustment Disorders

What Works	Currently no medication or psychological treatments meets these criteria.
What Seems to Work	
Interpersonal Psychotherapy (IPT)	IPT has the most support in that it helps children and adolescents address problems in their relationships so that they can become less depressed.
Cognitive Behavioral Therapy (CBT)	CBT is used to improve age-appropriate problem solving skills, communication skills, and stress management skills. It also helps the child's emotional state and support systems to enhance adaptation and coping.
Stress Management	Stress management is particularly beneficial in cases of high stress.
Group Therapy	Group therapy is beneficial in cases of high stress.
Family Therapy	Family therapy helps in making needed changes within the family system. These changes may include improving communication skills and family interactions and increasing support among family members.
What Does Not Work	
Pharmacology Alone	Medication is seldom used as a singular treatment because it does not provide assistance to the child in learning how to cope with the stressor.

Anorexia Nervosa (AN)

What Works	
Nutritional Rehabilitation	Developing meal plans and monitoring intake of adequate nutrition to promote healthy weight gain.
Family Psychotherapy	Family members are included in the therapeutic process to assist in reduction of symptoms and modify maladaptive interpersonal patterns.
In-patient Behavioral Programs	Individuals are rewarded for engaging in healthy eating and weight-related behaviors.

Pharmacological Treatments	Used primarily after weight restoration to minimize symptoms associated with psychiatric comorbidities.
What Does Not Work	
Individual Psychotherapy	While effectiveness is uncertain, it may be beneficial during the refeeding process (not starvation) and to minimize comorbid symptoms.
Group Psychotherapy	May stimulate the transmission of unhealthy techniques among group members, particularly during acute phase of disorder.
12-Step Programs	Not yet tested for their efficacy and are discouraged as a sole form of treatment.
Somatic Treatments	To date, treatments such as vitamin and hormone treatments and electroconvulsive therapy show no therapeutic value.

Attention Deficit Hyperactivity Disorder (ADHD)

What Works	
Behavioral Classroom Management (BCM)	BCM uses contingency management strategies, including teacher-implemented reward programs, token systems, time-out procedures and Daily Report Cards. Clinicians or parents may work in consultation with teachers to develop a classroom treatment plan.
Behavioral Parent Training (BPT)	BPT teaches the parent to implement contingency management strategies similar to BCM techniques at home.
Intensive Behavioral Peer Intervention (BPI)	Intensive BPI is conducted in recreational settings, such as Summer Treatment Programs (STPs) have demonstrated effectiveness and are considered well-established. However, STPs are less feasible to implement than other evidence-based practices.
Stimulant: d-Amphetamine	Short-acting: Adderall, Dexedrine, DextroStat Long-acting: Dexedrine Spansule, Adderall XR, Lisdexamfetamine
Stimulant: Methylphenidate	Short-acting: Focaline, Methylin, Ritalin Intermediate-acting: Metadate ER, Methylin ER, Ritalin SR, Metadate CD, Ritalin LA Long-acting: Concerta, Daytrana patch, Focalin XR
Serotonin and Norepinephrine Reuptake Inhibitor (SNRI): Atomoxetine	Atomoxetine is unique in its ability to act on the brain's norepinephrine transporters without carrying other medications' risk for addiction.
What Does Not Work	
Cognitive, psychodynamic, client-centered therapies	Traditional talk therapies and play therapy have been demonstrated to have little to no effect on ADHD symptoms. ADHD is best treated with intensive behavioral interventions in the youth's natural environment.
Office-based social skills training	Neither once-weekly individual nor group office-based training have demonstrated significant improvement in social skills. (However, intensive group social skills training that use behavioral interventions are considered well-established.)
Dietary Interventions	Interventions include elimination of food additives, elimination of allergens/sensitivities, and use of nutritional supplements.
Antidepressants	Bupropion (i.e., Wellbutrin), Imipramine (i.e., Tofranil), Nortriptyline (i.e., Pamelor, Aventil), Clonidine (i.e., Catapres) and Guanfacine (i.e., Tenex).

Anxiety Disorders

What Works	
Behavior and Cognitive Behavioral Therapy (CBT)	Treatments that involve exposing children to the (non-dangerous) feared stimuli, the goal being that the child learns that anxiety decreases over time.
Selective Serotonin Reuptake Inhibitors (SSRIs)	Treatment with certain SSRIs, e.g., Sertraline
What Seems to Work	
Educational support	Psychoeducational information provided to parents, usually in a group setting.
Not Adequately Tested	
Play Therapy	Therapy that utilizes self-guided play to encourage expression of feelings and healing
Non-SSRI Medication	Treatment with antihistamines or neuroleptics
Psychodynamic Therapy	Therapy designed to uncover unconscious psychological processes to alleviate tension thought to cause distress.
Biofeedback	Minimal support

What Works	
Applied Behavior Analysis (ABA)	Behavioral intervention aimed at improving cognitive, language, communication, and socialization skills characterized by on-going and objective measurement of behaviors, implementation of individualized curricula, selection and systematic use of reinforcers, use of functional analysis to identify factors that increase or inhibit behaviors, and emphasis on generalization of learned skills.
Discrete Trial Teaching (DTT)	Behavioral intervention based on principles of operant learning; incorporates units of instruction used to teach and assess acquisition of basic skills; discrete trial incorporates same sequential components regardless of skills taught.
Pivotal Response Training (PRT)	Focuses on the most disabling areas of a child's autism by teaching children to respond to multiple environmental cues, increasing motivation, increasing capacity for self-management, and increasing self-initiations.
Learning Experiences: An Alternative Program (LEAP)	Peer-mediated interventions in an educational setting with children with autism and typical peer; individualized, data driven, and focused on generalizing learning skills across context through saturation of learning opportunities throughout the day; family involvement is a significant part of this intervention.
Pharmacological Treatments	May be considered for maladaptive behaviors and when behavioral symptoms cause significant impairment in functioning.
What Seems to Work	
Educational and Communication-focused Interventions, e.g., TEACCH	TEACCH (Treatment and Education of Autistic and Communication related handicapped CHildren) provides strategies that support the individual throughout the lifespan, facilitates autonomy at all levels of functioning, and accommodates individual needs.
Natural Language Methods	Speech and language pathologists often integrate communication training with the child's behavior program to provide a coordinated opportunity for structured and naturalistic language learning. Instruction in communication is designed to provide a generative tool that will serve many immediate needs throughout the child's life.
Picture Exchange Communication System (PECS)	Helps children with ASD acquire functional communication skills. Children using PECS are taught to give a picture of a desired item to a communication partner in exchange for the item, thus linking an outcome with communication.
Other Behavioral Interventions	Joint attention behavior training, which may be especially beneficial in young, pre-verbal children, shows promise for teaching children with autism behavioral skills. Social skills groups, social stories, visual cueing, social games, video modeling, scripts, peer-mediated techniques, and play and leisure curricula are also supported by the literature.
Occupational Therapy & Sensory Integration Therapy (SI)	Occupational therapy helps develop self-care skills, e.g., dressing, using utensils, maintaining personal hygiene and academic skills, and shows promise in promoting play skills and establishing routines to improve attention and organization. SI therapy often is used alone or as part of a broader program of occupational therapy for children with ASD. Goal is to correct deficits in neurological processing and integration of sensory information to allow the child to interact with the environment in a more adaptive way.

Bulimia Nervosa (BN)

What Works	
Cognitive Behavioral Therapy (CBT)	The most effective independent treatment option; it is used to change underlying eating disorder cognitions and behaviors.
Pharmacological Treatments	Antidepressants, namely Selective Serotonin Reuptake Inhibitors (SSRIs), have effectively reduced binge/purging behaviors, as well as comorbid psychiatric symptoms.
Combined Treatments	A combination of CBT and pharmacotherapy seem to maximize treatment outcomes.
What Does Not Work	
Individual Psychotherapy	Compared to CBT, few individual therapeutic approaches have been effective in reducing symptoms.
Behavioral Therapy	Behavioral techniques, such as exposure, have been less effective than CBT techniques.
12-Step Programs	Not yet tested for efficacy and are discouraged as a sole form of treatment.

Depression/Dysthymia—Interventions for Children

What Works	
Stark's Cognitive Behavioral Therapy (CBT) - child-only group or child group plus parent component	Stark's CBT includes mood monitoring, mood education, increasing positive activities and positive self-statements, and problem-solving.
What Seems to Work	
Penn Prevention Program (PPP)	A CBT-based program that targets pre-adolescents and early adolescents who are at-risk for depression.
Self-Control Therapy	A school-based CBT that focuses on self-monitoring, self-evaluating, and causal attributions.
Behavioral Therapy	Includes pleasant activity monitoring, social skills training and relaxation.

Depression/Dysthymia—Interventions for Adolescents

What Works	
Cognitive Behavioral Therapy (CBT) provided in a group setting	CBT for depression focuses on identifying thought and behavioral patterns that lead to or maintain the problematic symptoms.
Interpersonal therapy (IPT) provided individually	In IPT, the therapist and patient address the adolescent's interpersonal communication skills, interpersonal conflicts, and family relationship problems.
What Seems to Work	
CBT provided in a group or individual setting with a parent/family component	CBT for depression focuses on identifying thought and behavioral patterns that lead to or maintain the problematic symptoms.
Adolescent Coping with Depression (CWD-A)	Includes practicing relaxation and addressing maladaptive patterns in thinking, as well as scheduling pleasant activities and learning communication and conflict resolution skills.
Interpersonal Psychotherapy for Depressed Adolescents (IPT-A)	Addresses the adolescent's specific interpersonal relationships and conflicts, and helps the adolescent be more effective in their relationships with others.
Selective Serotonin Reuptake Inhibitors (SSRIs)	Fluoxetine is the only pharmacological treatment approved for youth by the FDA. Most effective when combined with CBT, although there is debate about the use of SSRIs to treat depression in youth.

Disruptive Behavior Disorders

What Works	
Assertiveness training: Group Assertive Training	School-based group treatment for middle-school youth
Parent Management Training (PMT) Programs	Programs which focus on teaching and practicing parenting skills with parents or caregivers include: • Helping the Noncompliant Child • Incredible Years Parent-Child Interaction Therapy • Parent Management Training to Oregon Model • Positive Parenting Program
Multisystemic Therapy (MST)	An integrative, family-based treatment for youth with serious antisocial and delinquent behavior. Interventions last 3-5 months and focus on improving psychosocial functioning for youth and families.
Cognitive Behavioral Therapy (CBT)	CBT emphasizes problem solving skills and anger control/coping strategies and includes: • Problem-Solving Skills Training • Anger Control Training
CBT & Parent Management Training (PMT)	Combines CBT and PMT
What Seems to Work	
Multidimensional Treatment Foster Care (MTFC)	Community-based program alternative to institutional, residential, and group care placements for use with severe chronic delinquent behavior. Foster parents receive training and provide intensive supported treatment within the foster home setting.
What Does Not Work	
Atypical Antipsychotics Medications	Risperidone (risperdal), quetiapine (seroquel), olanzapine (zyprexa), and Abilify (aripiprazole). Limited evidence for effectiveness in youth with intellectual disability or pervasive developmental disorder.
Stimulant or Atomoxetine	Methylphenidate; d-Amphetamine; atomoxetine. Limited evidence when comorbid with primary diagnosis of ADHD.
Mood Stabilizers	Divalproex sodium; lithium carbonate. Limited evidence when comorbid with primary diagnosis of bipolar disorder.
Selective Serotonin Reuptake Inhibitors (SSRIs)	Limited evidence when comorbid with primary diagnosis of depressive disorder.
Boot camps, shock incarcerations	Ineffective at best; can lead worsening of symptoms.
Dramatic, short-term or talk therapy	Little to no effect as currently studied.

Early-onset Schizophrenia

What Works	Currently, no medication or psychological treatments meets these criteria.
What Seems to Work	
Traditional Neuroleptics/First-generation Antipsychotics	Molindone, Haloperidol
Second-generation (atypical) Antipsychotics	Clozapine risperidone, olanzapine, ziprasidone
Family Pychoeducation and Support	Helps to improve family functioning, problem-solving and communication skills, and decrease relapse rates.
Cognitive Behavioral Therapy (CBT)	Includes social skills training, problem-solving strategies, and self-help skills.
What Does Not Work	
Psychodynamic Therapy	May be harmful for this population.

Habit Disorders

What Works	
Habit Reversal Therapy for Tic Disorder	Treatment increases awareness to the feelings and context associated with the urges and implements a competing and inconspicuous habit in place of the tic.
What Seems to Work	
Cognitive Behavioral Therapy (CBT) for recurrent hair-pulling (trichotillomania [TTM])	Treatment involves exposing children to the stimuli associated with the urge while challenging thoughts associated with high-risk situations.
Not Adequately Tested	
Massed Negative Practice	Treatment involves children over-rehearsal of target tic in high-risk ticking situations.
Pharmacotherapy	Prescription medications to treat habit disorders in children.
What Does Not Work	
Plasma Exchange or Intravenous Immunoglobulin Treatment (IVIG)	Blood transfusions to alter levels of plasma or immunoglobulin.

Juvenile Firesetting

What Works	Currently no medication or psychological treatments meets these criteria.
What Seems to Work	
Cognitive Behavioral Therapy (CBT)	Structured treatments designed to intervene with children who set fires.
Fire Safety Education	Includes information about the nature of fire, how rapidly it spreads, and its potential for destructiveness, as well as information about how to maintain a fire-safe environment, utilizing escape plans and practice, and the appropriate use of fire.
What Does Not Work	
Ignoring the problem	Leaving the youth untreated is not beneficial because they typically do not outgrow this behavior and ignoring these behaviors may even increase dysfunctional behavior patterns.
Satiation	The practice of repetitively lighting and extinguishing fire. Satiation may cause youth to feel more competent around fire and actually increase the behavior.

Juvenile Offenders

What Works	
Multisystemic Therapy (MST)	Integrative, family-based treatment with a focus on improving psychosocial functioning for youth and families.
Functional Family Therapy (FFT)	Family-based program that focuses on delinquency, treating maladaptive and acting out behaviors, and identifying obtainable changes.
Multidimensional Treatment Foster Care (MTFC)	As an alternative to corrections, MTFC places juvenile offenders who require residential treatment with carefully trained foster families who provide youth with close supervision, fair and consistent limits, consequences and a supportive relationship with an adult.
Cognitive Behavioral Therapy (CBT)	Structured, therapeutic approach that involves teaching youth about the thought-behavior link and working with them to modify their thinking patterns in a way that will lead to more adaptive behavior in challenging situations.
Dialectical Behavior Therapy (DBT)	Therapeutic approach that includes individual and group therapy components and specifically aims to increase self-esteem and decrease self-injurious behaviors and behaviors that interfere with therapy.
What Seems to Work	
Family Centered Treatment (FCT)	FCT seeks to address the causes of parental system breakdown while integrating behavioral change. FCT provides intensive in home services and is structured into four phases: joining and assessment; restructuring; value change; and generalization.
Brief Strategic Family Therapy	A short-term, family-focused therapy that focuses on changing family interactions and contextual factors that lead to behavior problems in youth.
Aggression Replacement Therapy (ART)	A short-term, educational program that focuses on anger management and provides youth with the skills to demonstrate non-aggressive behaviors, decrease antisocial behaviors, and utilize prosocial behaviors

Non-Suicidal Self-Injurious Behavior (NSIB)

What Works	Currently no medication or psychological treatments meets these criteria.
What Seems to Work	
Cognitive Behavioral Therapy (CBT)	Involves providing skills designed to assist youth with affect regulation and problem solving
Dialectical Behavior Therapy (DBT)	Similar to CBT, but additionally involves an emphasis on acceptance strategies.

Obsessive-compulsive Disorder (OCD)

What Works	
Exposure and Response Prevention (ERP)	Individual child (probably efficacious); family-focused individual and family-focused group treatments (possibly efficacious). ERP meets well-established criteria for adult OCD.
Selective reuptake inhibitors (SRIs)	Clomipramine: Approved for children age 10 years and older. Recommend periodic ECG monitoring.
Selective Serotonin Reuptake Inhibitors (SSRIs)	Newer than SRIs, SSRIs primarily affect the serotonin neurotransmitters: Fluoxetine (Prozac): Approved for children 8 yrs + Sertraline (Zoloft): Approved for children 6 yrs + Fluvoxamine (Luvox): Approved for children 8 years +
Not Adequately Tested	
Cognitive Therapy only Psychodynamic Therapy Client-centered Therapy	Systematic controlled studies have not been conducted using these approaches.
What Does Not Work	
Antibiotic Treatments	Antibiotic treatments are only indicated when the presence of an autoimmune or strep-infection has been confirmed and coincided with onset or increased severity of OCD symptoms.
Herbal Therapies	Herbs such as St. John's Wort have not been rigorously tested and are not FDA-approved. In some instances, herbal remedies may make symptoms worse or interfere with pharmacological treatment.

Pediatric Bipolar Disorder (PBD)

What Works	Currently no medication or psychological treatments meets these criteria.
What Seems to Work	
Mood stabilizers/ Anticonvulsants	Lithium, divalproex sodium
Second-generation Antipsychotics	Clozapine, risperidone, olanzapine, quetiapine
Family-focused Psychoeducational Therapy (FFT)	Family therapy format. Helps adolescents make sense of their illness and accept it, along with their medications. Also helps to manage stress, reduce negative life events, and promote a positive family environment.
Child- and family-focused Cognitive Behavioral Therapy (CFF-CBT)	Emphasizes individual psychotherapy with children and parents, parent training and support, and family therapy
Multifamily Psychoeducation Groups (MFPG)	Child and parent group therapy has been shown to increase parental knowledge, promote greater access to services, and increase parental social support for youth.
Not Adequately Tested	
Interpersonal social rhythm therapy	No current evidence of its usefulness for youth.

What Works	Currently no medication or psychological treatments meets these criteria.
What Seems to Work	
Multisystemic Therapy (MST)	Intensive family and community-based treatment addressing the multiple factors of serious antisocial behavior in juvenile sexual abusers.
Residential Sexual Offender Treatment	May be necessary for public safety. For offenders, addresses both sexual and non-sexual behaviors and provides milieu treatment that is delivered by trained staff in a highly structured setting. Length of stay varies.
Community-based Programming	Effective element to treatment continuum; offers advantage of shortening residential lengths of stay, and improving post-residential transitioning.
Not Adequately Tested	
Selective Serotonin Reuptake Inhibitors (SSRIs)	Impacts sexual preoccupations, sex drive, and arousal.

Substance Use Disorders

What Works	
Cognitive Behavioral Therapy (CBT)	A structured therapeutic approach to teaching youth about the thought-behavior link and working with them to modify their thinking patterns in a way that leads to more adaptive behavior in challenging situations.
Family Therapy	Aimed at providing education, improving communication and functioning among family members, and reestablishing parental influence through parent management training. *NOTE: Only specific family therapies have been tested; not ALL family therapies are considered effective.*
Multisystemic Therapy (MST)	An integrative, family-based treatment focusing on improving psychosocial functioning for youth and families.
What Seems to Work	
Behavioral Therapies	Treatment which focuses on identifying specific problems and areas of deficit and working on improving these behaviors.
Motivational Interviewing Approaches	A brief treatment approach to increase motivation for behavior change. It focuses on expressing empathy, discrepancies, avoiding argumentation, rolling with resistance, and supporting self-efficacy.
Some Medications	Psychopharmological medication can be used for detoxification purposes, as directed by a doctor. Medication may also be used to treat comorbid mental health disorders.
What Does Not Work	
Interpersonal and Psychodynamic Therapies	Methods of individual counseling often incorporated into the treatment plan and focusing on unconscious psychological conflicts, distortions, and faulty learning.
Client-centered Therapies	Creates a non-judgmental environment, such that the therapist provides empathy and unconditional positive regard. This facilitates change and solution-making on behalf of the client.
Psychoeducation	Educates youth on substance use and may cover topics like peer pressure and consequences of substance use.
Project CARE	Raises awareness about chemical dependency through education and training.
Twelve-Step Programs	Uses steps as principles for treating addictive behaviors.
Process Groups	A type of psychotherapy that is conducted in small groups which can be specialized for specific purposes; therapy utilizes the group as a mechanism of change.

What Works	
Trauma-focused Cognitive Behavioral Therapy (TF-CBT)	Treatment that involves reducing negative emotional and behavioral responses related to trauma, by providing psychoeducation on trauma, addressing distorted beliefs and attributes related to trauma, introducing relaxation and stress management techniques, and developing a trauma narrative in a supportive environment.
What Seems to Work	
School-Based Group Cognitive Behavioral Therapy (CBT)	Similar components to TF-CBT, but in a group, school-based format.
Not Adequately Tested	
Child-centered Play Therapy	Therapy that utilizes child-centered play to encourage expression of feelings and healing.
Psychological Debriefing	An approach in which youth talk about the facts of the trauma (and associated thoughts and feelings) and then are encouraged to reenter into the present.
Pharmacological Treatments	Treatment with selective serotonin reuptake inhibitors (SSRIs).
What Does Not Work	
Restrictive rebirthing or holding techniques	Restrictive rebirthing or holding techniques may forcibly bind, restrict, coerce, or withhold food or water from children and have resulted in some cases of death and are not recommended.

Youth Suicide

What Works	Currently no medication or psychological treatments meets these criteria.
What Seems to Work	
Dialectical Behavior Therapy (DBT)	Outperformed the treatment for the control group in reducing suicide attempts. However, it did not help reduce depressive symptoms.
Cognitive Behavioral Therapy (CBT) Interpersonal Therapy Psychodynamic Therapy Family Therapy	Psychotherapy, while not by itself an evidence-based practice, is an important component to the treatment of suicidality in youth. A minimum standard of therapy should be adapted to the youth. All are options when choosing a treatment modality.
Selective serotonin reuptake inhibitors (SSRIs) for co-occurring disorders	Necessary to closely monitor youth taking SSRIs because of the risk that SSRIs can increase suicidality in youth and young adults under age 24.
What Does Not Work	
No-suicide Contracts	Study findings are diverse; there have been results which find that that using the contract reduces suicidal behavior and others suggesting that they increase suicidal behavior.
Tricylic Antidepressants	Not recommended because their effectiveness has not been demonstrated. They can potentially be lethal due to the small difference between therapeutic and toxic doses.
Benzopines	Should be used with great caution as they may result in impulsivity.
Barbiturates	Should be used with great caution as they may result in impulsivity.

Appendix C

Decision-Making in Selection of Evidence-Based Practice, Burns 2008

Seven Important Considerations

1. Is Study Population Comparable to Your Population?

(Age, Gender, Race/Ethnicity, Clinical Profile)

2. Are Outcomes Meaningful?

3. Do Intervention Characteristic **FIT** with Setting and Modality?

(Agency and Community, Setting: Clinic, School and Home, Length of Intervention, Family Component, Individual or Group, Level of Training Required)

4. Does Intervention **FIT** with Agency Needs and Resources?

(Training Available, Location of Training, Length of Training, Cost, Follow-up Coaching/Consultation)

5. Do Monitoring and Reimbursement Requirements **FIT** with Agency?

(Fidelity Measure Available, Fidelity Required, Specification of an Outcome Measurement, Medicaid Reimbursement)

6. Does Intervention **FIT** with Clinicians?

(Openness to Evidence-Based Practice, Compatibility with Theoretical Orientation, Expectation of Parent Involvement in Treatment)

7. Does Intervention **FIT** with Youth and Family?

(Values and Preferences, Individualized, Family-Centered, Choice, Flexibility, Culture)

Appendix D

The Evidence-Based Practice Attitude Scale, Aarons, 2004

0	1	2	3	4
Not at All	To a Slight Extent	To a Moderate Extent	To a Great Extent	To a Very Great Extent

Item	Subscale	Question
1.	3	I like to use new types of therapy/interventions to help my clients.
2.	3	I am willing to try new types of therapy/interventions even if I have to follow a treatment manual.
3.	4	I know better than academic researchers how to care for my clients.
4.	3	I am willing to use new and different types of therapy/interventions developed by researchers.
5.	4	Research-based treatments/interventions are not clinically useful.
6.	4	Clinical experience is more important than using manualized therapy/interventions.
7.	4	I would not use manualized therapy/interventions.
8.	3	I would try a new therapy/intervention even if it were very different from what I am used to doing.
		For questions 9-15: If you received training in a therapy or intervention that was new to you, how likely would you be to adopt it if:
9.	2	It was intuitively appealing?
10.	2	It made “sense” to you?
11.	1	It was required by your agency?
12.	1	It was required by your supervisor?
13.	1	It was required by your state?
14.	2	It was used by colleagues who were happy with it?
15.	2	You felt you had enough training to use it correctly?

Appendix E

System of Care Community Survey
Agency and Organization Respondents Reporting Statewide Participation
N=19 respondents

Which method would you like for us to use to contact you if we have questions?

- 1 phone
- 18 email

What county/counties does your organization/group represent?

All 19 respondents serve the entire state.

What ages of children/youth does your organization/group represent?

All ages (3), 0-3 (2), K-12 (12), 13-18 (1), and workers (1)

Please check which of the following partners are involved in System of Care in your area:

- 16 MH/DD/SAS LME-MCO
- 15 Families
- 11 Youth
- 11 Public Health
- 11 Family Organizations
- 7 Youth Organization
- Other: Head Start; faith-based organizations
- 11 Community Care of NC
- 16 Social Services/Child Welfare
- 2 Vocational Rehabilitation
- 18 School System
- 12 Juvenile Justice
- 12 Service Provider Agencies

Does your System of Care have formal or informal relationships with other child service sectors? Check all that apply

	Interagency Agreement	Consultation Provided	Co-location of Staff	Informal Access to Staff for Care Coordination
Education	8	5	4	8
Child Welfare	6	3	3	6
Juvenile Justice	7	3	2	8
Health Care	7	4	2	7
MH/DD/SAS Disabilities	9	7	1	7
Don't know	4	3	6	4

Does your System of Care in your area involve a single county or representatives from multiple counties?

- 1 Single county
- 16 Multiple counties

Are you or someone from your organization active members of your local community collaborative?

- 12 Yes
- 6 No

How frequently does your local community collaborative meet?

Monthly (8); twice a month (1), quarterly (1), don't know (1)

What is the primary function of your local community collaborative?

- MCO updates, Agency updates, staff cases.
- Local providers meet to discuss struggles.
- Our organization is not a member of any local collaborative.
- Getting the word out regarding organization.
- Discuss trends and let others know what agencies are doing.
- Information sharing and strategic planning.
- Student updates, information sharing and agency information.
- Child find & interagency collaboration for LICC meetings. Service Coordinators with the CDSA, the family, and I meet for development of the IFSP and for monitoring of services.
- Information sharing
- Identify gaps in services, be a voice for unmet needs, review access to service to ensure ease.

Do you or someone from your organization regularly participate in Child and Family Team meetings?

- 11 Yes
- 7 No

Do you or someone from your organization regularly facilitate Child and Family Team meetings?

- 7 Yes
- 8 No

If you answered no, which organization/system partner typically calls and facilitates Child and Family Team meetings?

- Case managers from our agency.
- Education or juvenile justice workers.
- County departments of social services.
- System provider.
- Your wording is strange, but if you are talking about meetings for the IFSP, the service coordinator with the CDSA facilitates that. LICC meetings are facilitated by the CDSA I believe. Beginnings works with the families, too, to educate them on hearing loss and transition processes.
- My organization does not provide direct service to families.
- DSS.

What are the sources of funding for System of Care implementation in your organization/system (including any specialized grants, or special allocations for specific projects)?

State funding (4), private funding (2), grants (2), organizational funding (1)

Does your organization/system require any System of Care training?

- 8 Yes
- 5 No

If your organization/system requires System of Care training, please list the following pieces of information about the required training.

Training Name:

- CFT 101, 201, 202, 203, 204.
- CFT from the Families Perspective: A Cross System Approach.
- NCCTI: system of care training.
- System of care trainings from LME/MCO usually.
- Step by Step: An Introduction to CFTs.
- CFT 1.
- We have had trainings in the development of the IFSP, and we used to have workshops about services in the state.
- System of Care.

# of Hours of Training: average of 11.4 hours, ranging from 8 to 18 hours.

- 10
- 11
- 18
- 10
- 12
- 11
- varies
- 8

Target Audience:

- Staff
- Everyone
- Case managers, IIH, day treatment, etc.
- Primarily child welfare workforce
- Providers, CABHA's and LME staff
- Service Providers, Teachers, etc.
- Dependent on Service Definition, but also taught in PreService to all staff (2 hours)

Are Family Partners included?

- 2Yes
- 2 No

What are the sources of funding for System of Care training in your organization/system?

- Organization - grants system - Cardinal Innovations and DSS.
- It is included in the bundled costs for programs.
- Only certain positions are required to get this training. We pay for it.
- We provide SOC training - CFT 1 from the Family's Perspective through our contract with Social Services twice a year in different locations.
- IVB-Subpart 2 of the Social Security Act, Promoting Safe and Stable Families. Also, Navigating CFTs is required for all facilitators. It is 18 contact hours.
- State funds.
- Grants, private funding, state funds.

- Agency revenue/training budget line item.

Does your organization/system actively work to include families and youth in all levels of System of Care (planning, training, implementation)?

- 12 Yes
- 3 No

If families and youth are included, please describe how families and youth are involved in System of Care.

- CFT meetings
- If families and youth are asked to participate they are compensated for their time. Family Partners do trainings, facilitate CFTs, sit on committees statewide and locally.
- Families and youth are involved in the CFT meetings and are included in the decision making process
- Youth and families create PCP goals, youth facilitates CFT meetings.
- System initiatives in education and JJ.
- CFT meetings, therapy sessions.
- We try to involve families and kids in all aspects of treatment.
- The Center has family partner trainers on staff, as well as a youth partner trainer on staff.
- Development of and delivery of training, policy development and review, and implementation of specific projects.
- Invited to attend team meeting and be an active participant in the treatment that the student is receiving.
- NCFU is invited to Division meetings regarding child mental health issues.
- Family helps develop the IFSP, and at age three they are involved in the transition meetings to develop the IEP.
- Families are included in planning and implementation, but not necessarily in the training of staff. Naturally our staff works with the family to help them understand the SOC concept & understand its value in their or their child's treatment.

Please describe efforts to recruit families and youth for involvement in System of Care.

- They are part of the planning of treatment. Without the family we can't treat the children unless they are in DSS custody
- We are always actively looking for families and youth to participate.
- Families and youth are involved in SOC throughout their time in our care.
- System initiatives in education and JJ
- Our Center has a Training Coordinator who is in charge of supporting recruitment and development of family partners and youth partners as well as larger programming around families and youth.
- Via relationships with contracted agencies, IE. SAYSO collaborates to develop youth leadership to provide input on policies/practices, the Center for Family and Community Engagement trains family/youth to provide CFT training, Prevent Child Abuse NC develops parent leadership to provide feedback in strategic planning efforts for the prevention of child abuse and neglect.
- Workshops, training, etc.
- Constant communication and invitations to Division meetings.

- School-based teams are encouraged to include students and families, but is not mandated

Please rate how much progress your community/organization/system has made towards creating, expanding, or generating the following:

	None	Some	Moderate	Significant	Extensive	Don't Know	Average
Home & community-based services & supports	1	5	5	3	1	0	2.9 (15)
Individualized, wraparound approach to service planning and delivery	1	4	6	3	2	0	3.1 (16)
Family-driven & youth-guided services	1	3	6	4	2	0	3.2 (16)
Family & youth involvement in the planning & delivery of their own services	1	2	4	4	3	0	3.4 (14)
Use of evidence-informed & evidence-based approaches	0	1	4	3	7	1	4.1 (15)
Political & policy-level support at the state level	2	4	1	6	1	2	3.0 (14)
Political & policy-level support at the local level	0	5	2	6	0	3	3.1 (13)
Partnerships with provider organizations, management in provider organizations, MCOs, etc.	0	2	3	9	1	1	3.6 (15)
Partnerships with civic leaders & other key leaders	1	4	4	6	0	1	3.0 (15)
Ongoing training, TA, & coaching	0	3	7	3	3	0	3.4 (16)
Capacity for ongoing training, TA, & coaching	0	4	4	5	2	1	3.3 (15)
Ongoing training on evidence-informed & evidence-based approaches to support high-quality & effective service delivery	0	5	4	4	2	1	3.2 (15)

Does your community/organization/system have fidelity measures in place to ensure that System of Care is being implemented with fidelity?

- 1 Yes
- 10 No

If your community/organization/system has fidelity measures, please describe them.

- Bi-monthly conference calls with evidence based practice agency to ensure model fidelity.
- Not system of care specifically, although some of our fidelity measures do assess some features of system of care

Are trainings offered by your organization/system open to other members of the community and system partners?

- 10 Yes
- 5 No

Does your organization/system have an orientation to System of Care for new employees/group members?

- 5Yes
- 8 No

If your organization/system has an orientation, please describe what it looks like and how it is conducted.

- On-line http://nccti.org.
- SOC and CFT trainings for new employees.
- All employees that require SOC trainings is based on the service definitions of their respective positions.
- There is online registration and information is given to new employees. I'm not sure what the actual training looks like.
- 2 hour PowerPoint to describe how the various state systems interact with each other and with the agency. Describe importance of system work and collaboration

What other trainings have you accessed that have been beneficial to the implementation of System of Care?

- Family Partner training.
- Trauma informed trainings, TCI, TCI-F, CARE.
- An Introduction to CFT: A Cross Systems Training; Keeping it Real: CFT with Youth in Transition; ABCs of Including Children in CFTs; Widening the Circle: CFTs and Safety Considerations. All available through CFFACE.
- Gang Conference, State of the Child.
- Various trainings on family engagement

What other clinical or system building practices have you accessed that have been beneficial to the implementation of System of Care?

- Policy requirement: Require convening a CFT before considering child foster care entry (safety permitting). Require CFT for family case plan development and quarterly review of case plan.
- Consulting service on a case by case basis.

Please indicate whether the following items have been challenges/barriers or strengths/supports to System of Care implementation in your area.

	Strength	Challenge	Don't Know
Treatment providers	3	10	0
Support from supervisors	11	2	0
Commitment from administrators	10	3	0
Commitment from families	6	6	1
Commitment from youth	5	6	2
Anxiety/fear about changing to a System of Care approach	4	4	5
Momentum	3	5	5
Adequate funding/resources	2	10	1
Collaboration with other child-serving agencies	6	7	0
Supporting policies/procedures	10	2	1
Funding for implementation and services	1	10	2
Advocacy	7	5	1
Training availability	8	4	1
Funding for training	2	10	1
Fidelity after training	2	9	2
Time for supervision	4	7	2
Supervisors trained in System of Care	5	5	3
Understanding/willingness to put family-driven practices in place	9	2	2
Other:			

What are other strengths of System of Care or things that are working in your area related to System of Care that were not listed above?

- I don't feel SOC is working. In theory it is a great model, but too much burden is placed on the provider with little to no support from the MCO's.
- Relationships with local school system.
- Strong support from Centerpoint SOC Coordinator in the review of cases and ensuring we have active family involvement.

How do you define System of Care?

- Like a quilt. It starts with pieces that no one wants anymore (our children!). But when you take those pieces, and put them with others and surround it with love and support (the piecing and quilting), it strengthens the family and supports the family.
- A theoretical wraparound practice in service to the needs of the child.
- A way of addressing the whole person and meeting health care needs through collaborative partnerships.
- I define SOC as the coming together of families, children, youth with various community organization, agencies, and other organizations to address and look at how to support the population of the community's access to resources, supports, trainings. I also see SOC as the place and forum for which systems can educate each other on the local and state levels as to how they practice, engage, and support families, children, and youth so as to promote healthier and more productive planning and practices which allow families, children, and youth to have their needs met in a way which meets them where they are at by eliminating agency barriers around access, language, "hidden rules", etc.
- Network of agencies working together to meet a goal.

- It's an interconnected system incorporating all providers of services and the individual/family. It builds on the community and the family strengths to support the client in all environments.
- Interagency collaboration that works to support the needs of children and families.
- I'm not that familiar with the term "System of Care", but I believe you are talking about the relationship between the family and the providers in the community. I'm not sure what you meant about "fidelity" after training. These questions are a little difficult to understand.
- The involved community members (formal and informal resources) coming together to support a child and family in their progress, with the child and family identifying the needs and directing the services.
- System of Care is a process through which communities (comprised of families, community members, and child and family serving agencies) work together to provide support to improve outcomes for children and families

Additional comments about System of Care:

- I wasn't sure how to answer these questions - it said community/agency/system, and I wasn't sure if I was supposed to do it for my community or my agency. Most answers are for community but Number 27, 28, and 32 were for my agency- NCFU.
- Not sure how many of our center sites are involved in a formal system of care -- but our comprehensive centers are all involved in some sort of System of Care.
- From my role at my organization - I am primarily involved in a more limited capacity than actually being a part of a SOC team on the local or state level. We have representatives from our staff/training team who participate actively in these conversations as part of their role so my not answering some of the questions pertained more to my role involvement, not involvement and information I have about our organization's involvement. We have a Networking Alliance team made up of various system members, community organization members, family and youth members that meets twice a year to share information, help inform our mission and practices, and network each other on the larger mission of supporting healthy families, communities, and organizations.

Appendix F

System of Care Community Survey
Agency and Organization Respondents Reporting Specific County/Counties Participation
N=251 respondents

Which method would you like for us to use to contact you if we have questions?

- 28 phone
- 224 email

What county/counties does your organization/group represent?

Of the 251 respondents, 22 respondents identified only one county SOC with which they were involved: Catawba, Chowan, Currituck, Dare, Davidson, Gates, Halifax, Hertford, Hoke, Jackson, Johnston, Lenoir, Lincoln, Mitchell, Pasquotank, Pitt, Richmond, Rowan, Rutherford, Swain, Washington, and Yancey. Twenty-nine counties had more than one respondent. The number of individuals who indicated that they worked with a single county totaled 104. For example, 10 individuals said they worked with Alamance County alone.

- 10 Alamance
- 3 Alexander
- 2 Alleghany
- 5 Ashe
- 3 Brunswick
- 8 Buncombe
- 2 Burke
- 3 Cabarrus
- 7 Caldwell
- 3 Carteret
- 2 Clay
- 3 Cleveland
- 3 Cumberland
- 2 Davie
- 3 Durham
- 2 Gaston
- 2 Guilford
- 2 Hyde
- 4 McDowell
- 6 Mecklenburg
- 2 Moore
- 4 New Hanover
- 4 Robeson
- 2 Stanly
- 2 Surry
- 6 Union
- 2 Wake
- 5 Watauga
- 2 Wilkes

One hundred twenty-two respondents indicated that they worked with SOC in two or more counties. For example, 7 individuals listed Alamance County, but they also identified at least one additional county. In order to be included in this count, the county had to be specifically identified. For example, “eastern counties” or “western counties” were not included in the count; 3 respondents answered in this manner.

- 7 Alamance
- 13 Alexander
- 11 Alleghany
- 5 Anson
- 11 Ashe
- 11 Avery
- 10 Beaufort
- 10 Bertie
- 4 Bladen
- 5 Brunswick
- 7 Buncombe
- 14 Burke
- 13 Cabarrus
- 15 Caldwell
- 14 Camden
- 6 Carteret
- 4 Caswell
- 10 Catawba
- 5 Chatham
- 5 Cherokee
- 13 Chowan
- 4 Clay
- 7 Cleveland
- 4 Columbus
- 9 Craven
- 3 Cumberland
- 16 Currituck
- 15 Dare
- 11 Davidson
- 7 Davie
- 4 Duplin
- 1 Durham
- 3 Edgecombe
- 8 Forsyth
- 4 Franklin
- 11 Gaston

- 15 Gates
- 4 Graham
- 4 Granville
- 3 Greene
- 4 Guilford
- 4 Halifax
- 9 Harnett
- 4 Haywood
- 10 Henderson
- 11 Hertford
- 14 Hoke
- 10 Hyde
- 10 Iredell
- 4 Jackson
- 5 Johnston
- 10 Jones
- 9 Lee
- 4 Lenoir
- 9 Lincoln
- 4 Macon
- 5 Madison
- 9 Martin
- 12 McDowell
- 9 Mecklenburg
- 9 Mitchell
- 9 Montgomery
- 9 Moore
- 3 Nash
- 3 New Hanover
- 9 Northampton
- 5 Onslow
- 5 Orange
- 9 Pamlico
- 16 Pasquotank
- 4 Pender
- 14 Perquimans
- 2 Person
- 10 Pitt
- 11 Polk
- 8 Randolph
- 5 Richmond
- 12 Robeson
- 4 Rockingham
- 14 Rowan
- 11 Rutherford
- 3 Sampson
- 12 Scotland
- 10 Stanly
- 6 Stokes
- 8 Surry
- 4 Swain
- 10 Transylvania
- 12 Tyrrell
- 11 Union
- 5 Vance
- 4 Wake
- 4 Warren
- 11 Washington
- 12 Watauga
- 4 Wayne
- 11 Wilkes
- 2 Wilson
- 7 Yadkin
- 9 Yancey

Thus, respondents that identified one or more counties totaled 248 of the 270. Three respondents did not identify which counties they served but are included in the analysis as they stated that they served more than one county even though they did not specifically name them.

What ages of children/youth does your organization/group represent?

- 213 respondents served children and youth from age 0 to 24.
- 36 said all
- 6 said from ages 3, 4, or 5 to adult

Please check which of the following partners are involved in System of Care in your area:

- 218 MH/DD/SAS LME-MCO
- 212 Social Services/Child Welfare
- 206 Juvenile Justice
- 201 School System
- 190 Service Provider Agencies
- 180 Families
- 159 Public Health
- 98 Youth
- 77 Youth Organization
- 73 CCNC
- 54 Vocational Rehabilitation

Does your System of Care have formal or informal relationships with other child service sectors? Check all that apply

	Interagency Agreement	Consultation Provided	Co-location of Staff	Informal Access to Staff for Care Coordination
Education	81	99	36	101
Child Welfare	75	89	19	100
Juvenile Justice	76	1	26	100
Health Care	49	71	20	76
MH/DD/SAS Disabilities	93	99	45	114
Don't know	77	78	107	73

Does your System of Care in your area involve a single county or representatives from multiple counties?

- 121 Single county
- 122 Multiple counties

Are you or someone from your organization active members of your local community collaborative?

- 220 Yes
- 24 No

How frequently does your local community collaborative meet?

- 187 Monthly
- 3 Quarterly
- 5 Every other month
- 2 Weekly

What is the primary function of your local community collaborative?

- Bring agencies, providers, professionals from all disciplines together and discuss needs of clients, families and impact on community while building relationships through collaboration and shared vision
- Identify needs, collaborate, information sharing
- To share information regarding health, mental health, substance abuse, education, etc.
- Partnership/collaboration to benefit children
- Systems level work occasionally at the child level
- Discuss System of Care Process and collaborate with the Juvenile Crime Prevention Counsel.
- Manages Care Review and coordinates SOC local training
- The LICC oversees early intervention, including Child Find, and provides governance for the Alliance
- To support positive family outcomes
- Our Community Collaborative has struggled with its function since the MCO has come into the county. The CC does try to oversee Care Review; provides information and updates to the collaborative on mental health issues. The CC has not been funded since the MCO arrived. The MCO indicates that it is not their responsibility to fund the Collaborative.
- It is a mechanism to better support and serve children and youth with serious emotional and behavioral challenges and their families. Families, child serving agencies, and other

community partners come together to share information and resources and develop new ways to support youth and families in the least restrictive safe environment that meets the needs of each individual child and family.

- Varies across the fifteen counties. Multiple counties did have funds that were overseen and utilized by the community collaborative to plan for community gaps, provide for youth and family supports, and support family partners within the system. The Community Collaboratives whose main function was one of financial planning are regrouping and re-establishing their missions. Other Community Collaborative that have not had funding are really supporting change in the community based on individualized community goals. All of the Community Collaboratives are highly representative of youth and family child serving organizations
- Communication
- JCPC and community collaborative meet together. Assess needs and gaps in the community, We assign funding to organizations to fill in gaps in community programing. Get mental health, DJJ, Education and other organization updates, etc.
- Discuss programming, troubleshoot, disseminate information
- Inform of new state initiatives and find the most effective ways to spend state money for services
- Improve the care for our community citizens.
- Community child protection team
- The primary function is case reviews and education involving youth services.
- Sharing information among community partners on new or innovative community based programs, identifying gaps in services, and conducting Child and Family Team meetings when children are in need of appropriate services and multiple agencies are involved.
- Discussion of community services that might provide safety and well-being for children in our community. We also staff DSS child welfare cases where that agency is seeking help/direction/guidance/suggestions from the community.
- Information sharing and coordination of resources
- The 15 counties are so different that each collaborative functions separate according to community needs and direction
- Varies by county-some counties have Care Review Teams, some collaboratives function more systemically
- Address gaps in services, coordinate efforts
- Typically, accessing mental health treatment for children.
- Service coordination and information sharing
- Education and resource linkage
- Address mental health/SA issues affecting the whole community
- Ensure that child serving agencies and resources are appropriately child and family focused, and driven by Child and Family Teams. The Community Collaboratives identify gaps in services and develop plans to fill those gaps.
- Identify gaps in services and finding ways to fill those gaps
- Information sharing and problem solving
- To meet and discuss what is happening in the various agencies
- Identify any gaps in service, coordinate care among child/family agencies, and promote children's services and new programs in the community.

- Networking, collaborating on community problems in meeting needs of family/youth served, identifying service gaps
- Coordinating, collaborating, networking.
- Share information, advocate for families, community education, collaborate and give opinions about system reform.
- Partners update each other about changes or projects in their system. Elicit assistance from each other. Programs that contract with MCO to provide unique services (family support through NAMI, Sub. Abuse Prevention, crisis bed provider, providers contracted through state funds, etc.) Report on their programs, announce opportunities for families. Collaboratives updated about JJSAMHP progress and DJJ sanctions development progress. Subcommittee of collaborative serves as care review.
- Everyone on the same page, we help one another
- To help link agencies and increase community involvement
- Sharing information, Needs and gaps identification, Problem-solving
- Discuss gap/needs. Share information. Gather resources.
- Child Collaborative - Assess the MH/SA needs of juveniles in the county; identify service gaps; educate members re: programs and services available; attempt to develop services based on need (former ECBH local funding); and outreach to parents for involvement in the Child Collaborative.
- Identify gaps/needs, community education, care review process upon request, vote/monitor programs funded with monies awarded to each county, sharing of information between agencies and providers
- Agencies to interact to inform
- To find gaps and needs and to find ways to close them
- Seek and offer assistance to at risk youth, youth with behavioral challenges, to improve the quality of life for families.
- To be determined
- Relationship between school and services
- Child Abuse and Neglect
- Information sharing We are trying to get them to focus on 1. Creating a Youth M.O.V.E. program and Family Partner and 2. Working towards getting all agencies that work with child/adolescent consumers to focus on trauma informed work
- Provide services to youth and family
- Discuss issues and challenges facing providers and families.
- Information sharing, SOC training and support, advocacy for identified gaps in service
- Provide support and collaboration between agencies and families to support CF team process, training, conflict resolution, etc. Support grant and/or other funding needs.
- Multiple functions--education, sharing info
- To facilitate communication of services, changes in systems and identify areas that are not working and how to improve services to families. One committee even reviews cases with CFTs that are stuck and not sure what to pursue next.
- Collaboration and agency updates

- Promote public awareness, advocacy and collaboration of stakeholders, families and agencies.
- Identify resources, promote awareness, advocacy for families and communities. To strengthen services through examination of resources, gaps, and barriers through the Child Welfare system
- To support and coordinate services for children and families.
- Identify services/resources for children and families
- Determine appropriate placement of children with special needs
- The collaborative focuses on mental health education supports for the community and information and/or training around evidence-based practices for providers. We also support family-based community activities.
- Smart Start, Child Care Connections (to enhance quality of childcare)
- Smart start, child care connections to be actively involved in community
- Share information about mental health changes, identify needs, collaborate in certain cases
- Coordination of community resources and information
- Share information across the county as well as discuss barriers and solutions.
- To promote the sharing of resources and accountability across agencies and programs on behalf of families and children who have significant mental health needs and build community capacity to provide effective, community-based, family and youth driven services that are delivered within a system of care philosophy.
- To come together and discuss any situations that are occurring.
- To form a seamless system of care for children and youth with mental health issues
- To work collaboratively with providers and others in the community
- To collaborate with agencies to identify the appropriate needs for the appropriate child at the appropriate time.
- To ensure that families and consumers get the appropriate care and are connected to all necessary service providers; to identify and address gaps in services for consumers; to offer Care Review Teams to consumers in need
- To identify gaps and barriers in the county to ensure services are provided in the most least restricted environment; To improve communication between the systems;
- To share information, identify service gaps, address community needs, create open lines of communication, collaboration of events/services/trainings/efforts, develop plan for implementation of SOC principles throughout systems, and identify opportunities for growth in all systems, and problem solve as a community to address issues/concerns.
- LICC is responsible for child find (of children with disabilities or delays)
- To discuss mental issues, changes in legislation and service availability
- To discuss mental issues, changes in legislation and service availability
- To discuss mental issues, changes in legislation and service availability
- Better address and serve mental health needs of youth in our county
- Collaboration related to barriers related to mental health issues, i.e.: placements, access, and continuity of care
- Address identified service needs in the community
- To come and address different issues identified

- Resource development, collaboration, and case consultation.
- Share information about mental health services for families
- Discuss needs of children and youth who have mental health needs
- To determine needs of the community, meet through funding, and stay abreast of ongoing issues.
- Shareholder reports and updates on SOC
- To talk about service provider available services, changes in state mental health procedures and definitions, promote training availabilities, discuss issues we may have, collaboration between agencies developed, speakers on services available, possible funding and funding review of organizations approved that are serving mental health needs in area.
- Identify gaps and needs, networking, education
- Networking & education/awareness
- Networking and staying abreast on the latest community resources.
- Community education on resources consumer advocacy
- Keep everyone in the loop of information/ changes in agencies
- Community networking of services in the community
- Sharing information
- It seems to be ineffective. It got combined with JCPC to merge funding but that is no longer the case.
- To advocate for needs of children with mental health needs, set priorities around and address gaps in service, share information across agencies
- Collaboration, identify service gaps, apprise each other of new services, strengthen family supports
- Apprise each other of new services and programs, identify service gaps, strengthen family supports, connect families to appropriate service available
- Child Protection and Child Fatality Review (or at least my portion of it)
- Provide communication about mental health services
- Identification of gaps in services and coordination with MCO to meet those gaps. Identified annual project goal for 2013-14 poverty.
- I belong to a domestic violence community collaborative, the DVAC, and chair a subcommittee on Mental Health and Substance Abuse.
- Develop community strategies to address mental health needs and create partnerships to create stronger resources in the community.
- Child and Family networking and information dissemination; putting on the annual System of Care conference
- To look at the needs and gaps of the community and to look at the resources available for youth and families in the community
- Sharing information.
- Share information, identify resources, identify barriers and solutions to access care
- Share information about services, resources and needs concerning children in our community
- Dissemination of information and coordination.
- To address service gaps in our county, and to decide how state dollars are spent to best serve children and families in our county.

- System of care reviews. Community involvement activities. Inter-agency care.
- Information collaboration of service in county and use of funds allocation
- Supporting and sustaining a system of care for children and families. A primary community collaborative goal is to address the hopes, dreams, and needs of children and their family so they can achieve success in home, school, and community settings.
- Interface, and learn about community partners
- To ensure the community, agencies and families are invested in System of Care. This is one way to create and enhance the sustainability
- Identify service gaps and system gaps within our community
- Make sure all person are at the table.
- Children and families
- Local Rules, community development, improving court practices
- Ensuring that clients receive all needed services
- To help solidify current services and fill in service gaps as much as possible.
- Discuss concerns and needs of services in the area and specific child concerns as needed.
- Build collegial relationships that support families that have individuals with emotional/psychiatric challenges, assure that child-specific funding is allocated for highest risk situations, training for families, professionals and community partners on topics related to meeting biopsychosocial needs.
- Address services, make sure children don't fall through the cracks. Staff difficult cases refer to care review if necessary
- It is not clear.....primarily for the MCO-SOC to give updates on MH and to staff difficult cases
- Coordination services
- Identify local service gaps/barriers, make recommendations to MCO, network, provide information about local resources, Care Review
- Partners communities and families to improve the lives of children/youth with SED within Franklin, Granville, Halifax, Vance and Warren counties
- Brainstorm with agencies and providers to address concerns about MH treatment for youth. Share ideas and get updates from MCO and Division.
- Information updates
- Updates on DHHS info, reports from partners, reports from private providers
- Staffing cases and distribution of monies
- To see how we can better our community for our children who receive help.
- Information sharing, networking..
- Provide care reviews, mental health updates, create community awareness
- To serve the needs of the community
- To ensure that the youth and family are receiving the best possible service.
- Coordinated care
- Make agencies aware of services for youth and families
- Provide funding to nonprofit organizations.
- To see what services can be provided to benefit youth and their family
- To find solutions to assist juvenile's and their families to take proactive roles within the community.

- To evaluate the service needs and gaps in the community, recommend ways to bridge service gaps, and collaboratively share resources and decision-making with the local agencies/providers to insure an adequate continuum of appropriate services and supports in the catchment area.
- Determine gaps and needs, discuss possible solutions and problem solve
- To identify children and needs for children in our community.
- Identify strengths, issues, barriers, funding, policy and legislative mandates that need to be addressed in order to develop a seamless Systems of Care.
- To staff youth and collaborate on services to aid the youth and their families
- Wraparound services for individual services to make them successful
- To identify gaps and needs in the community and to share resource information with other partner agencies
- To discuss issues in the community where improvement may be warranted; issues that are working well; ideas on how to address issues currently affecting the community as a whole.
- Exchange of information, ideas, resources
- Dissemination of information
- To discuss goals and strategies for improving the SOC
- To discuss best practice and provide updates on subcommittee's outcomes as well as discuss sustainability and service gaps within the community.
- Not sure, numerous activities and decisions are functioning individually instead of as a team.
- We are actually in the process of re-examining our prime function. Its prime functions used to center on planning, decision-making, coordinating system efforts, and holding partners accountable. We have gotten away from that. A current initiative involves steps to ensure that the SOC does not reflect 'just' mental health, i.e., that the other major systems have a clear role and are equal partners.
- The Governing Structure exists to promote the sharing of resources and accountability across agencies and programs serving children and youth, and to build community capacity to provide effective, community-based services and supports delivered in a manner consistent with System of Care principles.
- To find out what the gaps are in services
- Communication/updates
- To discuss service needs of children and youth in our community
- Attended training in DC on how to initiate. Have meet w/ coordinator to address plans and barriers.
- We have not met this year but the prior function was to ensure coordination of services, promoting public awareness/education, and networking.
- To share information on resources and systems changes, identify gaps in services and community needs, set annual priorities for funding assistance
- Provide information; discuss issues, make members aware of resources
- Inform and educate
- To network, share information, be creative with suggestions and feedback, wonderful group led by a superior leader...

- The types of services provided.
- Information sharing and collaboration
- To better the communication with the agencies who serve these families and promote bringing members of the community to the table.
- To improve coordination of services and understanding of available resources for families
- Haven't figured that out in a year of going to these meetings
- Information - care reviews
- Information - care reviews
- Targets high risk truancy cases and attempts to decrease dropout rates in schools
- Discuss services and needs. How to get more providers in rural areas
- To provide the best family centered services
- To keep everyone informed of resources, updates and to help improve communication between agencies. The collaborative also functions as a care review team as needed.
- To assist problematic youth in gaining the proper resources
- Share information about agencies, collaboratively work on trainings/information, support families
- Ensure all agencies work together to provide "needed" services to students and families.
- Identification of unmet needs, collaboration between providers and MCO, community outreach
- To discuss system issues, build relationships and share resources/ideas/information
- To provide services and let others know what is offered in our community
- We try to close service gaps
- Resource and referral
- Share information and improve services to children
- Share info about current children's & family services, identify service gaps, identify risks to current services (usually due to further funding cuts), struggle to figure out again & again how we can (with no money) help each other & the community meet identified needs
- Inter-agency coordination
- Child residential treatment foster care
- Identifying community agencies and resources in the community.
- To support parents of children with disabilities

<u>Summary of previous answers</u>:

- 67 Collaborate (6)/collaboration (14)/Collaborative (18)/partners (8)/collaborating (1)/building system relationships (5)/coordinate (15)
- 66 Sharing info (58)/communication (8)
- 39 Needs assessment (39)
- 38 Systems level work (38)
- 30 Resources (30)
- 21 Service development/improvement (21)
- 21 Care review (21)
- 20 Financial planning (1)/funding (19)

- 19 Public awareness/education (19)
- 16 System of Care (9)/SOC (7)
- 15 Children/family positive outcomes (15)
- 13 Service provision (13)
- 11 Networking (11)
- 10 Training (10)
- 7 Capacity building/community development (4)/sustainability (3)
- 7 Parent outreach (1)/family support (6)
- 6 Advocacy (6)
- 5 Problem solving (5)
- 4 Child protection/child abuse and neglect (4)
- 4 Child and Family Team meetings (4)
- 4 Oversee (3)/manage (1)
- 3 Accountability (3)
- 3 Child Find (3)
- 3 Community activities (3)
- 2 Empowerment (2)
- 2 Monitoring/evaluating programs (2)

Do you or someone from your organization regularly participate in Child and Family Team meetings?

- 201 Yes
- 42 No

Do you or someone from your organization regularly facilitate Child and Family Team meetings?

- 110 Yes
- 135 No

If you answered no, which organization/system partner typically calls and facilitates Child and Family Team meetings?

- 33 DSS
- 31 Treatment provider
- 13 Provider/social services
- 8 LME-MCOs
- 4 DJJ
- 3 CDSA
- 3 Provider/LME-MCO
- 3 DJJ/social services
- 3 Provider/DSS/DJJ/school
- 2 Mediation Center
- 2 ADR
- 1 Provider/DSS, school
- 1 Provider/school
- 1 MCO/school
- 1 MCO/DJJ
- 1 school/CDSA
- 1 School

What are the sources of funding for System of Care implementation in your organization/system (including any specialized grants, or special allocations for specific projects)?

- 38 Grants
- 24 State
- 21 none
- 19 LME-MCOs
- 13 Medicaid
- 11 County

- 2 Donations

Does your organization/system require any System of Care training?

- 89 Yes
- 137 No

If your organization/system requires System of Care training, please list the following pieces of information about the required training.

Training Name:

- 52 System of Care (21 of 52 also mentioned Child and Family Teams)
- 4 Mecklenburg County Training Institute
- 2 CPR and first aid
- 2 HIPAA
- 2 parent support, shared parenting
- 2 pre-service training
- 2 training for facilitators
- 1 abuse and neglect
- 1 Crisis Intervention Teams
- 1 JJAMSAMHP
- 1 Motivational interviewing
- 1 Person-centered planning
- 1 Sudden Infant Death Syndrome

# of Hours of Training:

- Mean of 15.0 hours, ranging from 1.5 hours to 72 hours

Target Audience:

- 30 Providers
- 18 Families
- 13 Collaborative, including 3 SOC
- 13 Social workers
- 9 School staff, including a school counselor and school social worker
- 2 MCO
- 7 Court
- 2 Nurses
- 2 Child and Family Teams
- 2 Family Partners
- 1 Law enforcement
- 1 Public health

Are Family Partners included?

- 40 Yes
- 8 No

What are the sources of funding for System of Care training in your organization/system?

- 21 MCOs
- 15 State
- 12 Federal grants
- 7 County/local
- 4 In-kind from participating agencies
- 4 Juvenile Justice Substance Abuse Mental Health Partnerships (JJSAMHP)
- 4 Juvenile Crime Prevention Councils (JCPC)
- 3 Medicaid
- 3 Training fee
- 2 Organization/agency
- 2 Headstart
- 2 Schools
- 1 DJJ
- 1 SOC

Does your organization/system actively work to include families and youth in all levels of System of Care (planning, training, implementation)?

- 172 Yes
- 52 No

If families and youth are included, please describe how families and youth are involved in System of Care.

- Panel night at MAPP with potential foster parents
- We employ two family partners; actively recruit family members for CFT trainings; active CFAC
- Treatment team meetings, development of goals, family therapy, regular communication between birth families and foster families
- Participate in CFT meetings and sometimes community collaborative meetings
- Training
- Besides involvement in CFT meeting we also have youth on our client rights committee.
- Seeking natural supports and having them be the driving force of the Child and Family Team.
- Co-train most trainings
- CFTs are scheduled (usually) around the parent's schedule.
- Family members or Family Partners sit on all boards and committees
- Our SOC supports a Family Involvement unit with 7 family partners (part time and full time) that are matched with families. We also support CM services for young pregnant/parenting teens. Parents/parent reps sit on LICC and all Alliance committees. Parents participate in quarterly family cafes.
- Serve on Alliance Committees
- The CC is actively working to revive the Family Involvement Committee. No significant progress has been made. We do have a youth rep for CC.
- If families and youth are asked to participate they are compensated for their time. Family Partners do trainings, facilitate CFTs, and sit on committees statewide and locally.
- We have historically tried to have family involvement but it has been difficult to maintain. Under the MCO we have a Consumer Affairs Specialist. We are also in the process of redeveloping the family involvement committee which has been inactive for quite some time. We have identified a parent liaison from the school system who recently took SOC module 1 and 2. She will most likely begin participating in Care Review, Alamance has a lot of parent partners for young children through the Alliance grant. We also have youth representatives at both JCPC/Community Collaboratives and have tried to maintain a parent representative on the collaborative but it has been difficult.
- Varies across the fifteen counties
- In Alamance families and youth have an opportunity to assist in the training as co trainers.
- Families are contacted prior to a CFT to get explanation of process and encourage them to invite natural supports to all meetings. Meetings are held at times and locations convenient for families. They are encouraged to communicate and express thoughts and feelings appropriately during the CFT. Try to ensure that the developed plan is something they will buy into.
- Service Planning

- Invitations are extended to the family and youth for Care Review, CFTs and school based meetings.
- During our last class we had two children from our links class to speak on panel night. We also include Shared Parenting classes in with our MAPP classes.
- Just a few . . .
- CFT meetings
- Smoky Mountain Center continues to develop strategies to engage youth and family members within our organization
- employs a family partner, Consumer and Family Support Team members as well as partnering with CFAC that make decisions in funding, Levels of Care, types of services, etc. It is VERY difficult to external child & family involvement.
- CFT meetings, satisfaction surveys
- They participate in child and family team meetings; and in the goal making process of the PCP/treatment plan.
- CFT meetings
- In the four counties of District 22 we embrace the tenets of SOC "nothing about the family without the family" and Motivational Interviewing to engage children and families in the wellness process. We follow the law and our Division/Department policies which is fortunately focused on the goal of meeting the child's and community's safety needs, and preventing the child from becoming involved in the criminal justice system.
- Attending meetings, collaboration, reporting relevant information, and assisting in solutions
- Parents of children with special needs 0-3, are the vital part of services
- Only what we can provide and refer to Smokey Mountain Center for information
- Participate in treatment planning, monthly Child & Family team meetings, ongoing involvement in goal setting and interventions.
- Initial assessments, service planning and goals, team meetings, progress update meetings
- Everything is family driven
- We actively seek individual and family input into decisions that are made systemically and always involve individuals and families in decisions about their care.
- Parents of MH youth are involved in running our family support program. They are available to sit in on CFT or IEP meetings for families as needed. They run parent support groups. They attend collaborative meetings and are members of most of our JCPC councils in at least 6 counties. A parent is also a member of our JJSAMHP Leadership Team.
- They are present in the meetings
- As active participants to provide information from their perspective
- Several Collaboratives have parent members.
- Family representative on Community Collaborative (only 1 county); participation in Child & Family Team meetings
- Via referral and community awareness
- They are invited to collaborative meetings and ECBH has a family training partner.
- Contracted by DSS
- Family members attend the Community Collaborative
- They are invited to meetings and are encouraged to give input.

- At the meeting
- Active partners in Child & Family Teams
- Social workers and nurses work with families to coordinate access to community services and supports from provider agencies.
- Input at meetings and presence on the collaboration
- Family members serve on the committee, serve as trainers, and are part of the collaborative. We also provide stipends to families to pay for childcare while they are attending meetings and trainings.
- Families/youth are invited to participate in meetings and school activities.
- Via school meetings
- Families and youth are involved in implementation of SOC through education and experience during CFTs, etc.
- Child and Family Treatment Teams
- Participation on CFTs
- Most of our work is with children under 3 years of age. However, for all children and families our intervention supports involve building the capacity of parents to meet the mental health needs of their children through their everyday activities. Every family has a plan that includes child and/or parent goals and resource supports per family interest.
- Parent trainings
- Parent trainings
- They are the focus of the care
- Families are encouraged to participate and lead child and family team meetings. They are invited to collaborative meetings and to attend trainings.
- Participate on Community Collaboratives. Participate on Care Review Teams. Participate in Child and Family Team trainings.
- By always being able to express their thoughts and ideas.
- Parents of youth with mental health issues are invited to participate in SOC meetings.
- I haven't seen any evidence of this - except at care review team meetings
- By participating in child and family team meetings by attending Care Review Team when warranted
- We are currently engaging Consumer Affairs as training partners for CFT TOT training and request their participation in CFTs and Care Reviews. A youth conference is being developed for October 2013 in Union County to support development of Youth MOVE chapter in that area.
- Families help create the IFSP (Individualized Family Service Plan) and participate in all sessions in the home.
- They actively participate in treatment team meetings
- They actively participate in treatment team meetings
- They actively participate in treatment team meetings
- LME advocacy positions and board representation
- Participation in developing case plans and input for CFTs
- Involved in decisions on step-down, family /parenting training
- Families and youth attend child and family team meetings.
- Family members are welcome to attend Community Collaborative meetings, however, none currently do

- Families attend meetings
- Families are the key players at the table. They are invited and may call a meeting.
- Family members attend Community Collaboratives
- Group/family session, Parents involved in person centered treatment planning
- Families are involved in person centered planning process and involved in all Child/Family Team Meetings.
- It is an open meeting - many open up new programs to the community
- Both parties share the concerns in the home and listen to recommendations.
- Attend family and team meetings, the families give input into the development of their case plan. (person centered plan through Mental Health.
- Attend Child and Family Team meetings, they participate in organizing the meeting (inviting who they would like to attend), provide input in developing a case plan and implementing a case plan, and give input into how the plan changes.
- Attend community collaborative
- Children often attend and participate in their Treatment Team meetings.
- Families are encouraged to participate in Community Collaborative meetings.
- We work with abusers age 16+, and work with abusive men as fathers.
- Predominantly, it is through involvement in the Child & Family Team meetings; Our services are consumer focused and family driven. We incorporate them at all levels of programming from intake services to after care planning.
- Attend meeting, facilitate conferences
- They are full partners in the process
- Included in trainings; in-school presentations; CFTs
- We actively attempt to recruit families and youth.
- Meetings
- Plan care and treatment that is person centered
- The chronic problem facing active involvement is the scheduling for youth and working family members. Efforts are being made to rearrange meetings time accommodate those who may be interested, Socio-economic issues also are a major factor with regard to attendance and engagement.
- Family representative at meetings, and our SOC plans and conducts a "real life" Teen event yearly.
- Although we are working on this it has yet to fully materialize, where families and youth are include in high levels of planning, and implementation as it relates to the organization. Our families are more included than youth. We do not have any youth in high level decision making tables.
- BECOMING project, CONNECTED family support group, Durham System of Care (FT) family partner,
- At all levels
- Through therapists, individual research of resources
- Child Planning Conferences, Parenting Team Meetings hosted by Department of Social Services
- Educational planning and transitional planning

- If families and or youth cannot participate, meetings don't happen. OUR problem is families don't always know to include GAL so we are conveniently forgotten by DSS. (All of our cases are DSS involved.)
- We have identified families; unfortunately their participation is sporadic
- CFT meetings, advisory board, quarterly meetings.
- Collaborative meetings are open meetings. All are welcome to attend and participate in the meetings and on subcommittees and projects
- Host a Quarterly Parent Board of Advisory Meeting to discuss the business functionality.
- Always a challenge. Continuous effort to educate families about SOC. Families with little free time. Foster parents more likely to participate in meetings, training. Less stigma associated with foster children and MH needs than with biological.
- Attending meetings
- Participate/attend CFT meetings
- It is their meeting, they invite stakeholders/ supports
- Regular staffings with school, DSS, mental health, substance abuse
- Youth hardly ever, if families it depends on county. They can be the driving force and not invite agencies involved or they can just be part of a team.
- Part of CFT/ Involved in decision making process
- Vital part of the CFT meetings, invited to collaborative meetings
- Attend and participate in meetings
- Services are provided to assist youth in dealing with issue that may cause them to participate in delinquent behavior.
- Participation in meetings
- Families and Youth are recipients of direct services - including individualized therapy and support groups
- CC4C work with the parent to set goals for child and family.
- We have a parent in our group, because we meet during school hours, the school system didn't want us to take students away from instruction two hours each month.
- CFTs; case plan development and implementation
- CFTs, Direct provision of agency services and financial/medical assistance programs
- Therapy is designed to involve individual client as well as family.
- On our end, we include families in the collection and interpretation of data by producing reports about CFT functioning, holding focus groups or forums, etc. Most of this has ended now since the SAMSHA funding ended.
- They were included when we had a specialized SOC team. Now that it has been moved under the MCO, there appears to be little interest in outreach or sustainability.
- 100's of families are being reached through our family advocacy program.
- To attend our SOC MCTI trainings. Families can attend at no cost through our Parent Voice.
- Families and youth have played a meaningful role on the county's collaborative, the SOC's original planning team, and several of the committees, from social marketing to informal supports.
- All levels - committees, trainers, SOC Coaches, Care Review Team

- They participate by being actively involved in CFT, in having task to do as all team members, in having freedom of input as all team members, they are included and empowered to have a full role in the CFT and Team process.
- They attend
- Families are included. Many time there is no communication between the agency the family is working with and the school, so we are unaware there is assistance already in place.
- Both are included in planning meetings
- Some staff make HV with the identified client, which could be the parent or child, but work with the family as a whole referring for community resources. We refer predominantly to MH and DSS.
- IEP/504 meetings (identification, eligibility, service delivery), Attendance intervention at school and w/ judicial attendance council (JAC) , transitioning to or from mental health facilities.
- Families and youth are included via IDEA/Special Education policies and procedures.
- Parents serve on the FAN Parent Advisory Council (PAC) at MHA of the Triangle and also serve on the local Collaborative; youth participate in our Orange Partnership coalition which is represented on the Collaborative.
- For number 21, I am not certain;
- Invited to trainings as well as CFT meetings
- Participation in team meetings, coordination of services
- They dictate what works best for them, where they need to meet with partners and when. They like the support system structure.
- Child and Family Team Meetings.
- Involvement in creation and implementing treatment plans.
- Represented at meetings
- Represented at meetings
- Safe Babies Program (formerly ZTT) parenting classes; Collaborative with DJJ/court
- CFT Process
- We hold a care review team with SOC as needed. Families and consumer's attend these meetings.
- Participating in care review meetings, be willing to share relevant information about their family
- They are invited to participate in the SOC meetings.
- We have parents involved in the Community Collaborative, and we work to engage families in youth in other activities - such as efforts surrounding Child Mental Health Awareness Day.
- Through Medicaid authorized services
- They care called sometimes to talk about Bullying, on another occasion they spoke on prescription drugs & teens
- Review of treatment services and treatment planning on a monthly basis.
- Newsletters and quarterly family conferences
- We USED to have an active group of parents who were involved in our collaborative and who had great influence on our decisions. They were paid a stipend for their

attendance/participation, and child care was provided whenever we met outside of school hours.
- Planning goals on the IFSP in congruence with their current needs
- Invite.
- Trainings on various subjects within or across three counties.

Summary of previous responses:
- 104 Invite to attend meetings or they attend meetings (e.g., Community Collaborative, Child and Family Team, MCOs)
- 51 Participate in development of treatment plan
- 17 Offer training to families and youth or they attend trainings
- 16 Implement awareness activities
- 10 Involve families in school IEP plans/meetings/activities
- 6 Involve Family Partners

Please rate how much progress your community/organization/system has made towards creating, expanding, or generating the following:

	None	Some	Moderate	Significant	Extensive	Don't Know	Average
Home & community-based services & supports	15	48	59	67	21	26	3.1 (210)
Individualized, wraparound approach to service planning and delivery	15	52	55	61	25	27	3.1 (208)
Family-driven & youth-guided services	14	56	55	64	19	25	3.1 (208)
Family & youth involvement in the planning & delivery of their own services	13	57	53	58	22	28	3.1 (203)
Use of evidence-informed & evidence-based approaches	9	29	54	77	41	26	3.5 (210)
Political & policy-level support at the state level	27	56	35	37	8	69	2.7 (163)
Political & policy-level support at the local level	29	44	44	41	14	60	2.0 (172)
Partnerships with provider organizations, management in provider organizations, MCOs, etc.	13	34	54	71	39	24	3.4 (211)
Partnerships with civic leaders & other key leaders	26	44	58	42	19	44	2.9 (189)
Ongoing training, TA, & coaching	22	49	59	52	25	28	3.0 (207)
Capacity for ongoing training, TA, & coaching	24	44	54	36	18	55	2.9 (176)
Ongoing training on evidence-informed & evidence-based approaches to support high-quality & effective service delivery	21	40	49	49	29	45	3.1 (188)

Does your community/organization/system have fidelity measures in place to ensure that System of Care is being implemented with fidelity?

- 62 Yes
- 105 No

If your community/organization/system has fidelity measures, please describe them.

- Each program has satisfaction surveys administered at the end of services and these surveys are evaluated to determine needed areas of growth within Agency and related program in our Quality Improvement process. We also have discussions in our Client Rights Committee about SOC and the involvement of the client and family in the tx process. In CFT meetings the client and family input is sought and help guide the course of tx. At the time of admission the client and family are involved in the treatment development plan (PCP) and discharge planning is discussed with each and their involvement is critical to a success discharge with appropriately identified community supports to insure proper support is available.
- Surveys, consumer feedback, call center for complaints
- Corporate compliance HIPAA trainings conflict of interest forms
- Corporate compliance, conflict of interest forms
- They developed some evaluations give to families that is involved to prove fidelity
- Through evaluation of Alamance Alliance through Duke Center for Child and Family Policy
- Duke evaluation protocol
- Smoky Mountain Center Care Coordinators and the Family Partner attend and participate in the child and family team meetings. Smoky Mountain Center also requires provider participation in the CFT trainings offered by SMC. SMC is committed to the SOC model and has 5 certified CFT trainers.
- Sign confidentiality agreement at every meeting, along with sign-in sheet. Reminders at every meeting about confidentiality.
- Quality Improvement and Utilization Management departments continue to develop measures and share them when necessary
- Ohio outcomes measures
- Regular chart reviews and quality assurance reviews by an in-house reviewer
- QAQI over sees medical records to assure that all services are taking place as mandated
- Utilize structured agenda for Child & family Team meetings to ensure all elements are routinely covered.
- All Collaboratives operate under by-laws that are reviewed periodically; each Collaborative has goals that are reviewed regularly within the context of the meetings - goals are updated and new goals added as appropriate
- MOA and bylaws for each county community collaborative

- This is being created through QM -- Honestly, I have not seen what the measures are at this time
- Surveys
- Partner agreements specify what level of involvement is expected. Membership and leadership teams monitor data.
- SOC liaisons offer training and technical assistance to all service providers as well as participate in CFT meetings, Care Reviews, etc.
- System of Care liaison is available to assist with assuring implementation of SOC in the community and is available for assistance for any organization that may struggle in that area.
- We report within individual collaboratives, assess and report progress monthly and annually to the SOC; we also report to Cardinal Innovations' Executive SOC team
- Child Session documentation each month enumerates when we met and with whom. Extensive assessment every 6 months tracks progress of the child.
- Visits and collaboration with state coordinators.
- Our agency does, but private and for profit organizations seem to be more interested in dollars than outcomes. We use several APA approved pre and post tests for outcome measures with three different evidence-based treatments.
- SOC report on every dime spent.
- Child welfare data, outcomes of individual cases
- Child welfare data, outcomes of individual cases
- It is included through our CQI process and supervision
- Care Reviews, CFT meetings
- Several different methods. One being our Care Review process, Our Community Relations department, our Family Partner and Care Coordinators
- Wraparound fidelity assessment system (WFA) team observation measure (tom)
- Have a good review process to assess effectiveness.
- Oversight by MCO SOC Coordinator, knowledgeable providers and agency personnel
- Mental Health, Education, DSS and Substance Abuse Professionals are available for consultation with involved families
- Leadership recognizes need and fulfills.
- Audit tools with set audit times. Always a consultant ready to assist with any questions. Support available.
- They used to get fidelity data from UNCC, but I'm not sure how they might capture that anymore. They don't send us anything anymore.
- We - as the evaluation team - partnered with families, providers, and other stakeholders to develop multiple measures of implementation fidelity, including the Participant Rating Forms (completed at the end of child and family teams by members of the CFT). They were used during the funded evaluation but are not being used now, except in a school-based wraparound initiative involving multiple partners and a single school. As one note, these elements were in place; however, they did not 'ensure' implementation fidelity. They were used to provide feedback on how teams were functioning and the

degree to which their practices and processes reflected the tenets of the wraparound practice model. However, there was very limited receptivity to the data we shared. Notably, we were able to demonstrate that youth whose teams demonstrated higher fidelity to wraparound evidenced a faster rate of improvement and greater improvement in symptoms.

- Community Collaborative and Care Review Teams
- Personal outcome surveys
- I know that works very hard to ensure fidelity but do not know specifics
- Referral - reviews - team placements
- Referral - reviews - team placements
- Simply having a system in place for meetings, referrals, etc.
- I am concerned about fidelity to the CFT model and we are planning to gather data on this by having folks complete evaluations after attending CFTs. We would also like to provide training and technical assistance on this.
- Outcomes tracking

Summary of previous answers:

- 15 SOC implementation reporting and review, including goal/by-law review, MOA review, structured agenda review, and audit
- 10 Surveys, including consumer feedback, call centers, Wraparound Fidelity Assessment System (WFAS), Team Observation Measure (TOM), and Participant Rating Forms (completed at the end of child and family teams by members of the CFT).
- 7 Care/chart reviews
- 7 Outcome measures, including child welfare data and child session documentation and progress reports
- 6 Quality assurance/utilization management/QI
- 4 Trainings
- 3 Corporate compliance, conflict of interest forms, and confidentiality agreements

Are trainings offered by your organization/system open to other members of the community and system partners?

- 171 Yes
- 49 No

Does your organization/system have an orientation to System of Care for new employees/group members?

- 72 Yes
- 133 No

If your organization/system has an orientation, please describe what it looks like and how it is conducted.

- We may send them to the State training required and our PQI Director provides an overview of SOC
- Utilizes information regarding history of SOC and how it relates to current context
- A 2 day training with an agency and family member facilitating

- It's a county-wide SOC training...mentioned in question #19
- Noted above in required training; 4 hour overview of SOC within Alamance County conducted by MCO SOC Coordinator, DSS SOC Coordinator, Family Partner and Cultural Competence Coordinator from the Alamance Alliance
- Orientation occurs through school age SOC. Introduction to SOC and CFTs is provided with SOC coordinator, CLC coordinator, family partner coordinator as co trainers and occurs on a quarterly basis.
- Introduction to SOC and CFT's. Training includes what is Cultural Competency and what is Family Driven Care. There are 4 trainers including a Family Partner. The raining is 4 hours.
- SOC and CFT trainings for new employees.
- I send out flyers/announcements for System of Care training Module 1 and 2 but employees aren't required to attend and unless it directly affects their specific job, most do not take advantage of the training.
- Varies across communities. The counties with previous or current SAMHSA funding are formalized with training and overview
- In Alamance you have to take the SOC training when you are in a position that requires you to work with families.
- All employees are required to complete several days of orientation that include general company policies and procedures conducted by the approved staff trainer and within a predetermined timeframe must complete trainings required and outlined according to company and department specifics
- Part of Care Coordination Training Plan
- New staff attend the system of care training offered by the MCO.
- Orientation is done with all new employees by trained staff members. There are slides, worksheets and a test at the end of the orientation
- Smoky Mountain Center
- Partnering with co-workers; Early Intervention Policies and Procedures; etc., (really not sure)
- We take people with us if they are interested in being involved with the SOC Collaborative and prior to their attending they are referred to the SOC Collaborative person from Smokey Mountain Center for Orientation.
- Typically done by MCO within first 90 days of hire for IIH positions.
- It is a part of the new employee orientation and a SOC coordinator facilitates
- Site training for new employees; shadowing co-workers at collaborative meetings and also child and family team meetings.
- Generally a SOC Coordinator presents an overview of SOC and New Employee Orientation. Not having been, I think it allows for each unit to give an overview of their program.
- OJT & through initial/basic training
- All new staff to the organization go through trainings specific to each department.
- We discuss in initial GAL volunteer training and encourage taking SOC training when it is offered which has only been 2x in past 2 years
- New employees are asked to attend the training during the first 6 months of their employment.

- All SOC employees participate in SOC orientation
- Orientation is given at Child Care Connections or by supervisor
- Child Car Connections or by supervisor
- Standard training within the agency
- Great idea though!
- Staff are required to take a minimum of 6 hours of SOC training per our contract requirements.
- They participate in trainings with SOC staff.
- 2 hour session during new employee's orientation done by a SOC Coordinator
- All staff are educated on SOC and what CFT's are and how they are conducted during orientation. Our agency sends required staff to the formal SOC training held by the MCO or if needed sooner facilitates the training on a web based system to ensure compliance.
- Four week pre service training required for new child welfare staff. Principals of SOC are discussed at this training
- The pre-service training is requested for new child welfare social workers. The training is not specifically for systems of care; however, the principles are discussed extensively in the training
- AOC has on line orientation for the employee not related to the system of care.
- Annually held
- The SOC speaks with new employees and offer technical assistance when needed.
- Confidentiality, HIPAA training
- It is informal
- Part of new employee orientation
- Written module in new hire packets.
- We introduce the System of Care program and the policies and procedures
- Training has been offered and completed and would be available to new employees
- I received no formal orientation when I joined the local collaborative.
- Webinars and one on one trainings by regional consultants.
- We are holding one on June 4th . Partners staff are coming out to do an overview for our county and its leaders.
- Independent Study implementation to new volunteers with the use of a workbook and individual meetings to complete information in the workbook.
- Individual session. No staff changes have taken place since last year, however.
- Not very applied. Its classroom based - power point. The "200" level classes are better, but most people don't do those.
- MCTI orientation is done by a MCTI SOC trainer.
- We have to orient new members of our research team to the model and approach. The nature of the orientation has varied over the years, based on our specific role and function. It has been individually administered or done in small groups, with emphases on the basic components of the SOC philosophy and the wraparound practice model. We also take steps to ensure that our staff understand cfts and how they should function. In some instances, this has included viewing and rating tapes of demonstration or actual CFTs.
- The orientation is called Meck Cares and it is done by the family run organization ParentVoice.

- An introduction to SOC is included in FAN orientation of new staff.
- An overview as part of a 2 week new employee orientation
- New employees meet and greet all supervisors with each level of service ; employees are taken to every partnering agency.
- Computer based training.
- Durham does a Cross Agency Training to orient new employees from varies systems to come together and have orientation to SOC and community partners. This orientation needs to be expanded to Wake.
- Required training for providers of IIH.
- Director does orientation or there is a five hour training for orientation
- This is done in Raleigh at DPI
- New hire training
- Workshop with training on how to work with parents who have children with disabilities

Summary of previous responses:

- 65 respondents stated that their agency conducts SOC orientation/training; this training varies widely by agency and ranges in duration from two hours to two days. Two others stated it was integrated in the two-week or four-week orientation offered by the hiring agency. The method of training varies from individualized to small groups in workshops and online or computer-based courses.
- 22 respondents said that new employees/hires/volunteers are expected to take SOC training.

What other trainings have you accessed that have been beneficial to the implementation of System of Care?

- PCP, MI, CALOCUS, monthly CBT supervision with an outside consultant
- Trauma trainings, diagnosis, SIT-CAP
- Training through the Local Management Entity and through Social Services
- A Road to Family Driven Care WRAP CFT1&2
- CFT 1, wraparound learning collaborative
- Family-driven care; DSS SOC state trainings
- Extensive trainings in EBPs, trauma informed care, CLC, family driven care, etc. See below.
- Motivational Interviewing; Family Driven Care; CFT Facilitation Training; Primer Training at Georgetown Inst.; SOC Conference yearly.
- Family Partner training
- We have quarterly What's Up Breakfasts which have revolved around topics such as Evidenced Based Practices, Substance Abuse, etc. We will have a QPR training in May to promote suicide prevention and response. There will also be a training on Fetal Alcohol Syndrome presented through a SOC partner. One of the providers will be doing a parenting skills workshop in May. The school system is presenting an educational series for parents. There will be a training on Family Driven Care soon. Through JJSAMHP funding we will also offer SOC part 1 which will meet the requirements for providers. Will also be able to offer GAIN training to 3 providers in the JJSAMHP

partnership. Caswell will have a Mental Health Awareness Day in conjunction with its annual JCPC community awareness.

- Family Driven from National Fed. Of Families, CFT training and facilitation, Motivation Interviewing.
- CFT facilitator, CFT from the family's perspective, Motivation interviewing, etc.
- Person centered thinking training
- Death scene investigation training safety head trauma
- All basic trainings benefit form SOC
- Person-centered thinking, family partner 101, motivational interviewing, conflict resolution, WRAP, transition ready curriculum, basic mediation training.
- Online training through the NC Training website.
- The LME training for person-centered thinking and training
- Motivational interviewing
- I've taken Family Training and Train the trainer training
- CIT trainings to police in many counties. MCO currently sponsoring free Motivational Interviewing training and ongoing adopting best practices in substance abuse treatment teach case conference series with Paul Nagy. Regular trainings in parenting and MH issues to parent support group arranged by our family support program.
- Person centered thinking
- Usually attend ECBH spring training but did not attend in 2013
- JJ/SA/MHP trainings, MCO conferences, CFST in the schools training
- CFT Part II training; SIT-CAP and I Feel Better Now
- Trauma informed agency training
- Attended collaborative meetings
- CFT
- I have attended state meetings related to evidence-based mental health supports for infants and toddlers and state medical institute's recommendations for providing mental health supports for infants and toddlers. This information is important to the implementation of System of Care.
- Motivational interviewing and several other trainings
- Child and Family Team 1 and 2, Motivational Interviewing
- Completed CFT 1 & 2 and will be completing CFT TOT in October
- Trauma informed care
- CFT trainings
- Child and family team meeting trainings trauma focused tx training
- Person centered thinking training person centered planning training healthcare reform training
- SOC conference in Fayetteville
- Modules of training offered by the consortium of Beginning, CASTLE, etc.
- Gang involvement, best practice/evidence based practice
- Motivational interviewing
- Court improvement project (CIP) trainings
- Child and Family Teams Trainings
- CIP offers updates from ECBH in yearly trainings

- PCP PCT MI
- Leadership keeps us up on current state changes
- Intensive in-home skills for social service practitioner, various trainings that focus on different disciplines involved in SOC such as medical, mental health, legal and cultural training.
- Intensive in-home skills for social services practitioner; various training that have focused on different disciplines, such as medical, legal, mental health, substance abuse, ECTT; child and family team meeting trainings
- LME SOC training
- I access community training for licensure; I also offer clinical training on domestic violence/batterers to other clinicians in the community.
- Community connections conferences
- I provide the child and family teams: from the family's perspective training.
- Motivation interviewing and SOC training
- ACCESS, bullying topics, gang awareness
- Motivational interviewing, 7challenges, contingency management, trauma focused treatment, MST, Strengthening Families-Evidenced Based Practices are used in all areas of the collaboratives
- Child & Family Team trainings; Durham SOC training; Cross Agency Orientation; Seeking Safety; Parenting Matters; Darkness to Light; DSOC MH 101; Real World Training;
- DSS, schools have child and family training.
- Support group training, Educational classes training for Families of people with diseases of the brain including those with children
- AHEC sponsored trainings regarding systems work.
- Attended statewide System of care training when the initiative first started
- As a manager in a 3 county district I coordinate trainings and make it mandatory for my staff, although it is not mandatory for the division. Example my staff just completed mandatory SOC Phase 1 and SOC Phase 2 training. Each training was two days. Adhering to SOC principles are included on staff's performance evaluations. Unfortunately the partners (MCO, School, providers, family, etc.) are not required to be part of the training. The MCO "controls" these types of trainings and it is not sincerely enforced as a requirement for the providers. In all honestly, I do not see the MCO "believing in the principles."
- Child and Family Team training, Understanding SED in Children (Overview of MI in children), NAMI Basics.
- JJTC Quarterly for mental health and substance abuse
- We access training and workshops directly from the MCO - Eastpointe
- Facilitator training
- CFT training
- DSS sponsored trainings on issues in the community and how they deal with those issues. Trainings are designed to give an overview of what each organization's primary responsibilities are.
- Medicaid eligibility, NCTRACKS, REAP, CFT trainings
- Meck Cares Training Institute introductory and intermediate series

- MCTI Trainings , Person Centered Thinking, Trauma Informed Care, Wraparound, and Family Partner Training
- Trauma informed training
- Varied professional dev. Opportunities that promote multidisciplinary team efforts (child watch public forums annually)
- Participation in NCFU trainings and state Children, Youth and Families Collaborative meetings which always include an informational segment.
- Eastpointe training
- Provider training
- Eastpointe training
- Only two have been provided thus far
- Webinars, regional meetings, yearly required trainings quarterly meeting with other counties
- State Trainings that are directly related to my position.
- Behavior, classroom management
- Our LME offers occasional trainings on evidence-based practices, but none in SOC practices
- Online and CDSA meetings
- Parent workshops

Summary of previous responses:

- 19 Child and Family Teams (CFT)
- 14 Motivational Interviewing (MI)
- 8 Person-centered planning (PCP)
- 8 Trauma-informed care
- 6 Family Driven care
- 4 workshops for parents
- 2 gang awareness/involvement
- 2 SIT-CAP
- 2 WRAP
- 2 Wraparound

What other clinical or system building practices have you accessed that have been beneficial to the implementation of System of Care?

- Weekly Clinical Group with our Medical Director and having CCNC reps attend. Meetings with the local school officials and the county office. Meetings with DJJ reps. Meetings with local Primary Care Physicians.
- Implementation of the care review process; implementation of adult SOC
- Early Childhood EBP training done by the Center for Child and Family Health; Triple Training
- Extensive use of learning collaborative model for training and supervision of clinical practices with 5 clinical EBPs now available in Alamance. Also training on Motivational Interviewing, IY-P, IY-T, clinical assessment, screening and referral, and targeted trainings. Annual SOC MOU implemented between all child serving agencies, law enforcement, judicial services, United Way, medical services, county commissioners, etc. Development of cross agency release of information now utilized across SOC has been beneficial.
- Neutral facilitation. We have a neutral facilitator at DSS and one for the Juvenile Justice population. Care Review has also been very beneficial

- ABSS has recently offered a room for SOC activities including Care Review, cfts, and other SOC meetings. I think our biggest strength in Alamance is that folks are committed to participating in the process. Every fall we hold a half day for strategic planning. During this time, each of the committees develop goals for the coming year. There is also an informational presentation and networking. In Caswell, although there are fewer numbers, folks do seem to grasp the concept as evidenced by their participation in Care Review when they are needed and their reliance on the faith community and other community supports.
- Trauma training
- Inadequate resources for families to access mental health services, and/or placement without the child having to enter DSS custody. Inadequate service providers the area to address the full spectrum of needs with families, lack of timely information provided to families on the constantly changing nature of service provision, accessing services, and mental health changes from LME to MCO.
- Building Bridge: Consumers & Representatives of the MH and Criminal Justice Systems in Dialogue and A Tool of Hope: Building Bridges
- Juvenile justice treatment continuum.
- Involvement of other stakeholder agencies like DSS and DJJ.
- Training in motivational interviewing; and training in cognitive behavior therapy
- JJSAMHP, Reclaiming Futures
- I have been to conferences which were held several years ago and attended many classes there.
- NC Collaborative on Children Youth and Families
- Usually attend ECBH spring training but did not attend in 2013
- We train GAL volunteers to be active participants on Child & Family Teams and to encourage an environment where families and youth input is sought and heard.
- Meetings with representatives from DSS and Juvenile Justice
- Overall collaboration training and facilitation training along with training on true consensus
- Innovative Approaches has brought community providers together for dialogue and planning
- Care review
- Care Reviews Reclaiming Futures site
- SBIRT, SAMHSA's strategic planning model
- Initiatives with the local health department in Cabarrus Co.
- CIP: offers updates from ECBH in yearly trainings
- MI
- System building practices include CCPT, MDT's, Child Fatality Team, Child and Family Team meetings, local interagency trainings
- System building practices include Community Child Protection Team (meets quarterly); MDT (meets monthly); Child Fatality Review Team (meets quarterly); child and family team meetings; local inter-agency trainings (provided by SBI, REACH (domestic violence), DSS, Law Enforcement
- Mental Health Association collaboration

- Currently utilizing Reclaiming Futures Model to address youth Substance Abuse treatment gaps.
- TFCBT, CBT, Trauma informed care
- Webinars
- Integration of services with Reclaiming futures, Youth in Transition Initiative, JJSAMHP involvement, NC Child Treatment Program
- Trauma Focused trainings; Child & Family Team coaching & TA; educational awareness to clinicians via care coordination;
- Peer to peer support group training CIT training
- Chaired local collaborative for 5 years - key to this was a strong System of Care Coordinator from the MCO who lived in, knew the community, and had strong ties with multiple civic, providers, education and families.
- Through JJSAMH partnership I continue to push for better implementation of SOC but when the MCO does not understand their role in partnering with the key stakeholders it becomes a barrier.
- Local Collaborative and instant access to most local MH providers and agency personnel;
- None, although Henderson county partners with the Mediation Center for facilitating Child and Family Team meetings only in Henderson County.
- Motivational Interviewing Trainings offered by Dept. Of Health
- Darkness to Light
- Individual contacts with key members in each organization to build relationships.
- Working with local collaborative, medical providers, health practitioners and education agencies for exchange of information and program eligibility training
- I wish there was better sharing of data about kids receiving services that was transferrable across systems.
- Local, State and National Family Partner Certification Program
- Still working through the establishment of effective and legitimate crisis response plans with potentially suicidal students.
- Encourage school administrators to participate in Child and Family Team Meetings
- Encourage school administrators to participate in Child and Family Team Meetings
- Attending local SOC meetings.
- We have been working on developing our Care Review process in Wake County and Wake County staff traveled to Alamance and Durham to look at how they conduct their meetings.

<u>Summary of previous responses</u>:

- 23 Involvement of other stakeholders
- 7 Care review process
- 4 Working with juvenile justice initiatives, including Reclaiming Futures
- 3 trauma-informed care

Please indicate whether the following items have been challenges/barriers or strengths/supports to System of Care implementation in your area.

	Strength	Challenge	Don't Know
Treatment providers	97	101	23
Support from supervisors	151	34	38
Commitment from administrators	136	44	41
Commitment from families	53	144	28
Commitment from youth	39	149	33
Anxiety/fear about changing to a System of Care approach	47	80	88
Momentum	67	97	55
Adequate funding/resources	17	162	42
Collaboration with other child-serving agencies	149	57	19
Supporting policies/procedures	118	59	43
Funding for implementation and services	31	144	48
Advocacy	133	58	32
Training availability	101	75	44
Funding for training	49	107	65
Fidelity after training	39	98	82
Time for supervision	63	80	75
Supervisors trained in System of Care	78	70	71
Understanding/willingness to put family-driven practices in place	109	68	38
Other:			

What are other strengths of System of Care or things that are working in your area related to System of Care that were not listed above?

- Expansion of SOC into the adult service continuum and support from Partners BHM to do so. Communities have been very receptive.
- Working to improve areas where they have been concerns/issues
- High level collaborative support by leaders of child serving agencies
- SOC has been strong in Alamance for a number of years and is now seen as the way we do business in working with children/families. Grant funding has provided extensive supports that would not have been available otherwise and that has contributed to the strength and growth of our SOC.
- We collaborate well. SOC has been around since 2003 so folks have heard about it. People buy into the concept even if they don't always implement it. The SAMSHA grant has allowed us to expand to include young children. We have had an annual SOC Strategic Planning Day for the past 8 years. Neutral Facilitation for CFTs.
- I think we are regaining some momentum after the challenges of multiple system changes. I think it is strength that despite many challenges, we continue to consistently meet together to work as best we can to support the youth and families we serve. We have multiple committees and subcommittees that do the actual work around System of Care. For example, we have the Care Review Protocol which is constantly working on ways to improve the Care Review process. We are working on an orientation/reorientation to train folks to be better care review team members and/or participants.
- In Alamance County one of the strengths is that the Family ran Organization is located here and works well with the DSS Social Worker supervisor
- Great attendance - good leadership and great programs

- Working on combining community resources to make them more accessible
- System of Care is slowly bringing people to the table with their funding sources; headway is being made where communities and agencies are realizing that we must work together.
- A general value and belief in its effectiveness.
- Works well with Juvenile Justice cases but see other families that could use it but it is not implemented unless it is Juvenile Justice cases.
- We have a strong family support program. Our JJSAMHP team is very cohesive and invested in promoting SOC principles.
- Sincere interest of a core group in making System of Care work
- Funding from MCO to each county. While funding procedures have been challenging, our counties have still be able to serve youth in various capacities.
- Network of partnerships
- When it works, the teams are very effective
- The community knows this is our way of doing business. Monthly CFTs are the practice and no surprise to anyone involved with youth as this is how we do business.
- I don't know as in the approximate 5 years I have been participating on the Child Collaborative no one has ever reported on how the System of Care was working for our community.
- Care Reviews are facilitated if a child is being referred to a higher level of care (Level 3 or PRTF). Counties have several SOC boards: JCPC, CCPT/CCFT, Multi-disciplinary teams, SAPC, School Safety Task Force, Reclaiming Futures Initiative.
- Best groups I work with
- Collaboration
- We work with each other; strong collaboration of county agencies
- Our team is close and communicates well together but the process is not effective.
- It's hard to point to actual strengths of SOC. I fully support the concept of System of Care as I define it but I'm not sure there is clear understanding across agencies or since the initial trainings were held a while back when we first implemented the SOC approach.
- A regional Smoky Mtn. Continuum of Care collaborative meets every two months that includes the 7 western DSS Directors, MH providers, and the LME. The purpose of this group is oversight of the mental health services, add new services as needed etc. The school system and Juvenile Justice are being invited to join this group.
- Continuum of Care developed as collaborative project between Smoky Mountain Mental Health, mental health providers, DSS, and school system
- SOC is a holistic approach that incorporates youth and families in the entire treatment process; recognizes and builds on their strengths; Overall, it is a comprehensive model
- It works!!!!!!
- Our SOC coordinator, , is very knowledgeable and responsive to the team's needs. She is available to assist in identifying appropriate resources and how to access them for our children and families.
- Other working collaboratives that have begun the process of developing resources.
- Agencies and providers work together well.
- Reclaiming Futures Juvenile Drug Court, the Youth in Transition Initiative, Reclaiming Futures initiative in all four counties

- We have a Durham County Common Consent form which agency partners all sign. This allows us to disclose PHI amongst partnering agencies.
- Serving a lot of counties without staff in place
- Court Counselors in the District have received the training and are expected to follow.
- Healthy Carolinian Initiative (Lee County) - instant access to local health/MH leaders focusing on access to MH services, a great local collaboration!
- Open Communication
- Agencies are communicating!!
- I loved it in Buncombe County.
- I am unsure exactly what is meant by system of care, therefore, difficult to answer survey. Some mental health providers work well with Division of Juvenile Justice.
- Education, collaboration and coordination of services.
- More resources for family involvement
- Dedicated staff/administrators.
- Small county that works together, are vested in our youth population
- A general willingness on the part of all local area agencies to work together
- New director of AMH is trained in an SOC with better implementation.
- To see the collaboration of a team within a system is amazing.
- Family advocacy program, school outreach, availability to train and support, resource information
- Our strengths lie in cultural competence and collaboration.
- amazing and a great resource for all partnering agencies.
- It has succeeded in uniting multiple child-serving agencies and motivating them to adopt SOC core values.
- Availability of staff to come into schools is great.
- Cooperative meetings and belief in process
- Cooperative meetings and belief in process
- The local SOC assists in disseminating information about trainings and opportunities via email in between meetings.
- Simply being visible and actively be available to the community and families
- We hold each other accountable professionally. We are finally working together instead of feeling like an island trying to move mountains. WE ARE making a difference in families and children's lives.
- We are excited about our school based mental health team and we are working on cross agency training and rolling out free CFT trainings!
- CDSA presentations we are doing to make our new intake system
- The best is that an actual family member can work with the child. The pay is so low that typically you get an uneducated non caring untrustworthy person.
- Accessible and approachable

Summary of previous answers:

Sixty-three respondents identified additional strengths of SOC. Thirty-three noted the high level of collaboration among participating stakeholders. Other strengths included working together to improve SOC and its effectiveness (13); strengthening resources in the community

(6); publicizing training and other opportunities (4); support from the community (3) and MCO (1); and inclusion of families and youth in the treatment process (3).

How do you define System of Care?

- SOC is the involvement of the family and the client who are involved in mental health programs and experiencing significant issues through identifying appropriate supports that they feel or believe will provide them with the support to continue success accomplished in treatment after treatment is discontinued. SOC involves the client, family, provider, schools, DJJ, DSS, family members, friends, church or local agencies.
- It is family driven at all levels of the system. It is also collaboration to achieve positive outcomes for all MH/IDD/SAS consumers.
- A system that is family and child focused, evidence based collaboration with many agencies on achieving community goals.
- Families, youth and communities coming together for the good of our youth
- A system that works for everyone in the community and is family driven and not guided.
- To me, SOC is the philosophy of WORKING TOGETHER including all the agencies that are working with a family, along with the family and their community supports, so that the family can get the help they need.
- The utilization of a comprehensive family driven, youth guided, community approach to serving the whole child that honors the individual child and family.
- A framework for organizing and coordinating services and resources into a comprehensive and interconnected network that is family-driven and culturally competent, with the goal of ensuring that children are safe and successful at home, in school, and in the community.
- Community organizations/agencies working together to support families and children
- SOC is a model (endorsed by the Federal Government) of how we should collaborate across agencies to serve children who receive services in more than one child serving agency.
- Like a quilt. It starts with pieces that no one wants anymore (our children). But when you take those pieces, and put them with others and surround it with love and support (the piecing and quilting) it strengthens the family and supports the family.
- The simplest way I know to define it is families, child serving agencies, and all community partners working together to support families and youth in their communities. It means working together to come up with solutions to serve youth in their own homes and communities if at all possible and if not, in the least restrictive safe environment. It is true collaboration and partnership rather than pointing fingers at others and/or simply trying to shift costs to make one's own numbers look good.
- One family, one plan, one team all working together to create success for the family in their community. As well as making sure the child is successful in school.
- A full circle of care around the family empowering both the child and the family to be successful.
- Families and agencies working together to form one team to develop one plan for the family

- Multiprofessional team collaborating with families and youth to ensure all their needs are met.
- Including everyone who touches a child in a positive way to build a plan offering that particular child a better future.
- The services and programs available to assist our families in our community.
- System of Care is wraparound supports and services provided by all agencies who are involved in the child's care. It is family driven and supported.
- Collaboration and coordination of community based services for families and children that include multiple stakeholders such as education, mental health, service providers, DSS, and juvenile justice.
- Everybody coming together to try to find good outcomes for our citizens that need our help
- Pulling together the client with resources in the community both private and professional
- Children, youth, families, agencies and communities building partnerships that focus on what we do well to address the needs and concerns of its residents to help everyone be productive and succeed achieving their goals and plans.
- A philosophical approach that supports the consumer and their family in accessing the right level of care in the right amount in a way that actually benefits the person being served. Its services being provided for the family to support the family's needs rather support the providers' billing needs.
- Continuum of services that allow for high level of collaboration and that is family/youth driven.
- All agencies and systems working together to address family and youth needs as defined by the youth and their family.
- System of care is the practice of using all trainings, educations, rules, regulations, and agency/state policies to provide necessary services to all children, youth and families in an effort to meet their mental health and substance abuse needs in a manner that is safe, ethical and meets requirements of best practice.
- Each organization, or group that has stake in the development, nurture, and care of a child working together to bear that awesome burden.
- Being able to pull together a vast array of services/providers who will actively work together to ensure that families have access to and are able to receive the services they need
- System of Care services helps families to access services that could help them succeed with difficulties in their life. Rather than telling them what they need to do they help the family access what they need and work together to help the families succeed.
- A coordinated, family centered model of providing services
- System of care is a model that incorporates all of the significant child-serving entities in a collaborative way to holistically impact the life of a child, while respecting that child's individual strengths and needs, encouraging the child and his or her family to take the lead in treatment decision.
- Helping connect the child and family to services that are based on them and their needs.
- All organizations that contribute to health, education and counseling within a community

- A framework for the optimal delivery of supports and services for children and families that (1) is collaborative in nature, (2) is youth-focused and family-driven, (3) uses strength-based and culturally-appropriate practices, and (4) includes families (and youth when appropriate) in the planning, delivery, and evaluation of supports and services.
- A collaborative between people with shared interest.
- Community approach to managed mental health care; identify needed MH/SA services for children, ensure the services are locally accessible, and ensure that parent(s)/juvenile(s) are aware of the services and are able to access services in a timely manner; support seamless service delivery and work together to manage challenging cases so no juvenile falls through the cracks.
- One active team working together to provide services to youth and families.
- Community Collaborative organization
- Simply: everyone involved in child/family's life coming together to work together making things better for the identified consumer, using guiding principles of SOC.
- All agencies work together to achieve the best possible result for a child. Personality conflicts, competition among the various group members, constant staff changes, incompetent care-givers, unwillingness to share information
- It is all the resources needed for families to be able to thrive.
- A system that actively seeks families and youth as partners in planning how to meet the needs of youth and families
- Partners in the community and schools working with families to find effective solutions to challenges they face in meeting the needs of youth.
- A strength based approach that allows youth and families to lead in the planning of their services allowing one plan with all of those supports and providers involved with the family, to allow for non-conflicting goals that will meet the families' needs.
- One child, one meeting so all are at the table to coordinate wrap around care.
- System of Care (SOC) is a methodology used to provide adequate and efficient services to children and youth. The methods associated with the SOC include the participation of all agencies and providers involved in the coordination of services for a single individual. This includes: DSS, foster care, schools, guardians, court system, family, and the person identified as the recipient of service.
- Family driven, youth based, community supported, and culturally sensitive to the needs of those served.
- Collaboration among community members, stake holders, and families to ensure that appropriate services/resources are put in place that strengthen the family's ability to improve and maintain a high quality of life
- In a very general way - a system that appreciates and encompasses family/youth participation as well as related resources into creating family/youth driven goals.
- Providing necessary resources for staff and parents to meet their personal needs
- Providing necessary resources for parents and staff to meet their needs
- As coordinating effort with the family so they are not dependent on paid services
- System of care is a way of doing business that start with the families wants, desires and dreams and include all other systems involved with the family to make it come to past.

- SOC is a network of coordinated and integrated community resources which work together collaboratively to support adults, children, and families with a full network of services and supports to meet their needs based on their individual strengths. The goal is to work in partnership with individuals and families who need services or resources from multiple human service agencies to be safe and successful at home, in school, and in the community and through this assistance, make the community a better place to live.
- A collaboration between agencies to identify the appropriate services for the appropriate child at the appropriate time.
- System of Care to me is a collaborative designed to make sure that youth and families receive 360 degree, individualized care, with access to all necessary providers and partners. The SOC works to alleviate barriers to treatment for our consumers and to provide consistent, reliable service and information to every individual we serve. We work on the macro level to improve the quality of our communities' services and expand our service offerings, and we work on the micro level to address the needs of individual families.
- Partnerships with individuals and families who need assistance from agencies to become self-sufficient and to make the community better with everyone achieving the goals for a better way of living.
- Wrap around services for children and their families that integrate a variety of programs as needed.
- True implementation of SOC principles throughout community systems with support/validation by policies/procedures from the state-level agencies to local community agencies.
- All of the people on the 'team' working together / collaborating to provide excellent services for a family with a baby / toddler with hearing loss...Audiologist, pediatrician, ENT, CDSA service coordinators, pts, ots, slps....
- A system of services that will come from different perspectives i.e. providers, juvenile justice, mental health, school etc.
- A system of services that will come from different perspectives i.e. providers, juvenile justice, mental health, school etc.
- A system of services that will come from different perspectives i.e. providers, juvenile justice, mental health, school etc.
- A group working in collaboration to provide for the mental health needs of our youth.
- Total wraparound services for youth and family
- A System of Care is when all stake holders and service providers in a community come together in order to identify gaps in services, problems with access to services, form partnerships through collaboration, empower families and youth to assist in improving services in their communities.
- System of Care is the collaboration of multiple human services agencies to provide a comprehensive network of services and resources to families who have mental health needs.
- Clearinghouse for mental health services
- When treatment providers, managed care, involved agencies, the community, families and children come together to work to put an appropriate treatment plan together in the

best interest of the child/family to follow the treatment - and make changes when changes are needed.

- All agencies and providers working together to support families in accessing needed services to help their children live the most complete life that they can regardless of MH/SA challenges.
- Connecting, linking and creating resources to support individuals in their communities. Assisting families and individuals in connecting 'the dots' (existing and newly created systems). Assisting families and individuals to own their own treatment by offering various supports that might be or might not be unique to their strengths and needs.
- Collaboration across agencies, families, and youth for the purpose of improving services and access and expanding the array of services
- When agencies have their resources to provide the services needed, and work with families not against them!
- Ineffective based on training. Based on the few times we've met, providers come ill-prepared to place children out of the home because the parents don't want to deal with the child.
- A cross discipline approach to providing community-based mental health/behavioral services that are family-driven and strengths-based to meet the individual needs of a child with all providers/supports on the same page collaborating.
- A collaborative family centered approach to use all available resources in the community to support each family's individualized needs.
- -Families driving the treatment process they are involved in - all agencies coming together in one Meeting to make it easier for the family
- Collaboration among agencies and service providers working with children and families to ensure all identified needs are being met.
- Collaborative effort to meet the needs of children and families throughout the mental health system which includes the needs and services available within the catchment area.
- I have no clue.
- A multidimensional system that wraps services around youth and families to address mental health issues that are client centered and family focused.
- Collaboration of key stakeholders to ensure maximum service delivery to children and families.
- A framework of resources put together in the best interest of a family/youth.
- I am not sure I understand its definition. I only know in my role that we are constantly advocating for and fighting for the needs of children and families to be met, which can be very difficult.
- A System of Care is a child and family focused framework based on the principles of: •inter-agency collaboration •individualized, strength-based practices •cultural competence •community-based services •full participation of families at all levels of the system •Shared responsibility for successful results
- Collaboration of services to benefit individual and family functioning
- SOC is an opportunity to build around children and families, allowing them to be the architects of what they desire, how they define goals and what steps they wish to follow to attain what they have determined to be in their best interest. It is like a highway that

branches off in many directions, beginning at one central place-beginning with the youth and family. The SOC does not offer advice, but rather hears and sees and listens to what is most important to another who may have been, for too long listening to others. The SOC, at its very best, can be a wonderful partnership with the community and families.

- Collaboration of community resources coming together to share, learn, and provide advocacy for youth and families in our community.
- The Durham System of Care (DSOC) is an organizational framework, an approach, a way of 'doing business' driven by values and principles that enables our community to better meet the needs of children and their families. It is not a program, but a way to use teamwork to organize and support a coordinated array of community services and resources. This collaborative strategy seeks to help families respond to the real-life joys and challenges of raising children who experience serious/complex behavioral, academic, social, and/or safety needs by combining and targeting community services to address those needs. System of Care models the national standard of best practices that can be utilized to plan and deliver services to children & families with complex needs. Durham SOC is anchored in the integrated network of community services and resources and supported by collaboration among families, professionals, and the community.
- As a spider web
- A group of services across agencies that answer the needs of the whole person
- Network of providers working together to ensure participants get the services they need.
- A child and family focused framework utilizing the principles of inter-agency collaboration, individualized, strength-based practices, cultural competence, community-based services, full participation of families at all levels of the system shared responsibility for results.
- A community wide system of accountability to children and families where we work together to assure services are in place and services are available to meet the needs of all consumers
- Defined by my perspective as working with court involved youth: A scarce group of individuals, which may include the parent/guardian, sometimes the child, occasionally the lead in an enhanced mental health service, if requested the SOC coordinator, and the court counselor, meeting in an effort to support the client/family in developing a service plan to meet their life domains.
- The system of care model is an organizational philosophy and framework that involves collaboration across agencies, families, and youth for the purpose of improving services and access and expanding the array of coordinated community-based, culturally and linguistically competent services and supports for children and youth with a serious emotional disturbance and their families. The system of care philosophy is built upon these core values and guiding principles: The core values of the system of care philosophy specify that systems of care are: Family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided. Community based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level. Culturally and linguistically

competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.

- A philosophical approach to service delivery that encompasses principles involving: family centered practice, individualized plans, least restrictive, most clinically appropriate services, culturally and linguistically competent and sensitive services, early intervention, transition of services for youth into adult services, collaboration with all partners involved with family, development of natural support systems, family and team as partners in the process, ensuring services and communication are not duplicative, but are collaborative.
- It's a philosophy, a way of living to provide a wide range of related services and supports organized to work together to provide care of SED children and their families.
- A framework for offering community-based, individualized care and treatment for youth with health/mental health needs. Everyone involved in the child's care should be included in treatment planning which is individualized, family and youth focused, and based on the strengths of the family. A wide array of community based services should be offered which are EBP.
- Least restrictive services
- A seamless approach to care for families and children involved in mental health, substance abuse, educational needs and crisis.
- Everyone that is part of a family team is on board with the same idea of how to conduct a child and family team meeting to carrying out a wraparound plan.
- Is a model of coordinated services to families and youth that is supposed to eliminate barriers to receiving services that are family focused and purpose driven.
- My guess would be that system of care is a conglomerate of all working with the family and juvenile to provide/coordinate the needed services.
- Working together not in opposition.
- Different agencies with children and families to improve our community.
- Collaborative between community resources and MCOs/LME to provide services for individuals/families.
- A team working together from various agencies and professions to provide care, resources and education to families for the well-being of the child identified.
- Organized network of services and supports that help children be successful in their home, school and community.
- Wraparound services for each individual child
- System of Care should be a commitment by each individual organization to work together toward addressing the needs of family and youth within our community and coming to an agreement on how to approach the needs of these families without compromising each organization's unique strengths and responsibilities.
- Holistic approach to addressing the needs of families and individuals, whether the needs are physical, mental, financial or a combination of all.
- Collaborative, multi-systemic, community-based approach to addressing the needs of children with SED and their families, which includes the use of strengths and informal supports in a family-driven process for making goals and addressing with strategies.

- A philosophy of coordination of professionals and services to meet the needs of the children and families to help them achieve their own defined goals and improve their lives.
- Family professional partnership in which families and professionals collaborate capitalizing on each other's strengths and expertise.
- I see SOC as a philosophy designed to provide a comprehensive array of services and supports to address the needs of children with SED and their families. The system should function in a collaborative, coordinated fashion, utilize youth and family driven practices, employ culturally competent methods, and work to ensure that services and supports (and the locus of decision making) are in children's home communities.
- It is an approach to delivering services.
- To make sure the child and family are linked into all the services that are available.
- A team of service providers working with the child and the family/guardian of that child working together to identify how to best meet the needs of the child and implement them. Working with the family to identify not only immediate needs but long term planning for supports for the child
- Collaborative, intentional, full service delivery, evidence based practices, critical transitions run smooth.
- System of Care is an approach to client needs that involves collaboration between local child and family service sectors to ensure that supports are all inclusive.
- Parent led, family focused, youth driven, culturally competent
- Collaborative effort to provide services to families and students who are in need of mental health services.
- A network of people in various settings who come together to put a service in place to meet the needs of a person or family by providing services that help reduce barriers to more healthier growth and development. . A service that collaborates and coordinates with various agencies to create an easier delivery to families in need of support.
- All level approach among the different agencies in providing services to children and families served.
- Collaborative approach by a community/organization that assists youth and families meet unmet needs, by providing appropriate and effective services to meet those needs in order to strengthen the community..
- Family Driven strength based approach to serving families and the community
- Unsure
- Wraparound services coordinated to facilitate individual's progress
- Wraparound services coordinated to facilitate individual's progress
- Levels of services that offer as wrap around services for families.
- Pulling together of natural and community supports in order to help families
- A group of individuals and agencies that come together to provide a continuum of care to help those of our community achieve their goals.
- An avenue set in place to try to meet the needs of families in our community.
- Agencies working together to support families to overcome diverse challenges.
- SOC is an integrated network of community services and resources that helps families meet the needs of children and adults with serious/complex behavioral, academic,

social and/or safety needs. SOC is developed and supported through collaboration among families, professionals and the community.

- Involvement of family/client in ongoing services review, as well as collaboration of other agencies involved in the ongoing treatment.
- A seamless Strength Based Approach where families are full partners.
- People working together to provide the best care or support for children and their families
- What we used to have was wraparound care with team meetings involving representatives of every agency involved with the family plus at least 2 or 3 non-agency advocates for the family chosen by the family, tightly facilitated by facilitators trained in this model. It was obsessively strength-based and client-based. The planning/coordinating collaborative included HEADS of all related agencies plus all other people we considered key players in the community, plus parents and sometimes kids (we didn't do so well with getting kids on board but kept trying)
- It only cares about making money. They don't care about the clients. They are most concerned with the HIPAA laws.

Additional comments about System of Care:

- It works!
- Must have buy in from all partners and be institutionalized in all systems for it to reach its full potential.
- SOC efforts have been weakened with the MCO model. There is no clear vision for the community about SOC from the MCO. We have not received any funding for any SOC events/activities/training/CC since the MCO assumed responsibility. We need clarity on the role of the MCO and what they are expected to provide to the community. We also need clarity on the role of the SOC Coordinator at the MCO. We need an Implementation Bulletin to address these issues with enforcement from the state. The state must force implementation of SOC if it will continue.
- I wasn't sure how to answer these questions - it said community/agency/system and I wasn't sure if I was supposed to do it for my community or my agency. Most answers are for community but Number 27,28 and 32 were for my agency- NCFU
- I think it just makes sense when you are working with youth and families. It helps everyone be on the same page and prevents families from having to go to multiple meetings and sharing the same things over and over again.
- I see the importance of SOC and how it works.. My fear is that once the grant is over, SOC will not be top priority and due to funds being cut, new employees may not receive accurate training on the principles of SOC.
- We do not have SOC in our counties; need to have a team dedicated to providing this in Judicial District 22A!
- I know that System of Care works to build stronger, healthier children and parents therefore, making communities safer self-sustaining.
- As NC moves towards a more integrated care model of medical, dental and behavioral health, I hope SOC doesn't get lost in a commercial insurance model if there are not public CCE options.
- I believe that SOC is a powerful model and wish that it were available to families and that service providers were invested and supported to be a part of teams.

- Would like to see more in child and family teams in place before they get to Juvenile Justice!
- I need to express that these questions forced me to answer based on 28 different communities and how they operate. There is soooo much variance across the state in terms of community participation. Daymark's ability to participate at this level also varies greatly based on funding at the MCO specific level and how involved with children's services we are. I answered to the best of my ability; however, I would have given significant "caveats" for many questions.
- I am unfamiliar with a formalized System of Care for children and youth in Ashe. I'd be interested in hearing more about it and becoming involved.
- I know our county is working towards a system of care but I don't know about the progress or what has been done so far. Probably need to talk to the supervisor or director about more specifics about system of care and what has already been done and will be done.
- We have utilized the Care Review Team process a number of times in my five counties. In years past this process was driven by our SOC coordinators. This year I have "chaired" a Care Review Team with little or no guidance. I feel our SOC coordinators are best prepared to conduct a Care Review Team meeting. We don't have any more than 3-5 per year in my five county district, so it is not very time consuming but has proven to be extremely beneficial.
- If the principles of SOC are followed, improvements should be noted in all phases of a youth's life. If they are not followed there will continue to be problems in the home and community.
- Service Providers unable to effectively focus on what is best for the child-given all that occurs in #34
- Not followed by everyone with the same spirit of the intent. Often modified to suit the agency. Example: leaving children out of the conversation prior to "bringing them in." In effect, having two meetings when one meeting is called-- one to figure out what will happen, then one to tell the child what will happen.
- Please help get trained facilitators back into our region that can offer affordable SOC training to non-mental health professionals and require MCOs to adhere to the philosophy of SOC.
- Good idea that needs constant updates and maintenance to retain its efficacy
- Ideal, but the meetings continue to go around us without our knowledge until they have passed...
- I tried to call so that my responses could be shared anonymously - but was unable to leave a VM
- Wonderful!
- System of Care is beneficial to everyone involved.
- It is a challenge that the DJJ and DSS systems have dissimilar theoretical orientations that often cause strain.
- Our agency personnel often share new ideas and strengthen the skills of all personnel together!
- Due to the number of youth serving agencies that are billing Medicaid, children who should be getting trauma specific evidence-based treatment from specialists in child

abuse treatment are being told by some service providers that they cannot do so unless they also receive therapy services from them. This is disturbing. These people are playing with the future health of children over dollars.

- Our SOC has great leadership and advocacy.
- Would like to see an Adult SOC in Carteret Co.
- I think we say we have a system of care, and while our LCC meets and members are committed to the idea of a system of care approach - I'm not sure how much this is infused in the daily practice of staff (across all disciplines). This has become more challenging with constant changes in mental health service array and LME/MCO mergers, etc...
- Fantastic in Cumberland County!
- It works better for the one needing it than anything we have had so far
- It's great when it works but requires a very strong System of Care Coordinator, works best with the now non-existent work of case managers, fully inclusive participation by ALL parties involved with cases, and all parties understand that it takes time and may not be billable.
- System of Care on paper is great but it is difficult to implement when the key stakeholders do not believe in it!
- The System of Care services that we have provided by using the SOC Philosophy has worked in our communities, schools and surrounding areas.
- SOC has been very effective in assisting families with various needs and guiding them to the community resources available.
- Any agency involved with a child should have to be part of the team meeting this part should not be up to parents to invite or not invite. Mandatory for anyone involved with the child to attend a monthly child and family team meeting. I have noticed unless at school, the school does not participate and very limited on Mental Health since they do not get paid to attend.
- Request training, presentation and information on System of Care since I am lacking in knowledge.
- I attended one or two meetings for the continuum of care committee, but did not seem to fit our agency. Not sure if this is the same as System of Care. If it isn't then I do not know what System of Care is, so more training or knowledge on the program would be needed.
- The system of care is common sense and should be followed in everyday life, the problem here is once the grant money ran out, the system of care does not seem to be so pressing for collaboration any longer.
- I think our community struggled with implementation fidelity. I believe there was limited buy in by provider administrators / mid-level supervisors, so there was not as much support, coaching, mentoring, and accountability processes to try to ensure that that working to implement SOC and wraparound did so with fidelity. When people 'get it' and implement it well, I think it has great potential. Unfortunately, I do not think it was realized in our community.
- I supervise programs that will occasionally be a part of the model but not regularly, i.e. a pregnant teen or young child getting into the system (age 5). The school health RN would be more involved on a regular basis and could likely answer the questions better. I have forwarded this to them.

- The system works when all parties do their part and support each other for the good of the families we serve.
- I have attended 3 Community Collaborative meetings after receiving an invitation for community agencies to participate. There has been little orientation/training for participants who are not part of the DSS/CPS/JJS/MH system and therefore already familiar with the lingo and procedural practices, so I don't have a strong grasp of what the System of Care is about or is accomplishing.
- There is a severe lack of SA service providers for children and adolescence. This has been an ongoing issue that has yet to be addressed. Additionally, there is a population of children that have ongoing mental health challenges, where there is no long term support so the families have to resort more and more to out of home placements at a time when funding for those services are being limited.
- We love what we had and I totally believe it's the only we to provide family and youth services. Help Use regain what we had!!!
- The Wraparound care approach we had in the past was effective. It is a shame that is no longer possible.
- It was a LOT of work for 2 or 3 years getting the groundwork laid & implementing it gradually & responsibly, with documentation of outcomes, exactly as we were supposed to do. All the money went away just as we were starting to coast into our full (target) capacity. Our local area is stretched beyond max capacity for private funding of such things, and there has been no way to continue. We have always had extraordinary teamwork & cooperation among agencies & organizations, long before any State or federal requirements got involved. We continue to do what we can along those lines, but what we can do is extremely limited and getting more limited by the day. Our county commission just slashed its funding for almost every human service non-profit in the county.
- I am an educated advocate for my family member. I have a four year degree in nursing. I am also a tax payer. My husband has 3 farms so our county tax is mighty high. I think the service my family member has received has been a disgrace. My life revolves around him at this point. His autism is severe. He requires constant care. That agency refuses to go to IEP meetings with us. They are cold and non-caring. They can’t come up with goals for my family member. They leave that up to the hap techs, which are me and my husband. So, what good are they. The only reason I went to the agency was the case manager we had become a Q. I don’t think that went well and she lost her job. Oops, I guess I’m breaking those wonderful HIPAA laws. I’m in trouble already for breaking HIPAA laws and being insubordinate. Shame on me.....

Appendix G

System of Care Community Survey
Youth and Family Respondents
N=59 respondents

How long have you and your family been involved in System of Care?
Average of 6.9 years, range between 1 and 20 years

Are you a family member or youth?

- 41 Family member
- 9 Youth

What county/counties do you participate in System of Care?

- 3 Alamance
- 1 Alamance and Guilford (family partner)
- 1 Alamance and Orange
- 2 Ashe
- 2 Avery
- 1 Beaufort, Pamlico, Craven, Jones, Washington, & Martin
- 2 Buncombe
- 1 Burlington
- 1 Cabarrus and Guilford
- 1 Caldwell
- 1 Carteret
- 2 Chatham
- 1 Chowan
- 1 Chowan, Hyde, Perquimans, Tyrrell, & Washington
- 1 Durham
- 7 Guilford
- 1 Guilford and Wake (family partner)
- 1 Halifax, Franklin, & Northampton
- 1 Hertford
- 1 Martin & Washington
- 8 Mecklenburg
- 1 New Hanover
- 1 Onslow
- 1 Onslow and others (family partner)
- 1 Perquimans
- 1 Stanly, Cabarrus, & Wake (family partner)
- 3 Tyrrell
- 1 Wake
- 1 Wake and New Hanover
- 2 Washington
- 7 Watauga
- 1 Wilkes

Of the 11 respondents who indicated that they were family partners, only four said that they worked in more than one county.

How old are you (youth) or the family member who is involved in System of Care?
Average of 19.18 years, range between .17 years and 55 years

Please rate your degree of involvement in System of Care: Average of 3.4.

- 6 None
- 11 Some
- 9 Moderate
- 17 Significant
- 13 Extensive

How do you view your role in the System of Care?

- Parent, expert in knowing my daughter, advocate.
- In what I perceived as a System of Care (tho I don't know that it was called that per se)

in Ashe County, I was the parent of a baby diagnosed with a progressive neuromuscular/motor neuron disease (spinal muscular atrophy). Several years before, I had been a teacher of orthopedically- and multi-handicapped children in a self-contained school in Columbia, SC. I have also been consulted to help in some way with other NC families facing an SMA diagnosis, and I am very active online with SMA families choosing palliative care for their babies.

- I have been trained in System of Care as a participant and as a trainer but have never been utilized on any team.
- We came to a meeting for my child and to help me.
- 100% care in trying to fulfill all needs for the child.
- Reporter to the court.
- I'm family partner; co-chair of our system of care collaborative; teach child, family team training 1 and 2.
- To gather community members together to improve care for children and families with problems.
- Advocate.
- As a mother primarily and also as a Family Advocate working with families in my county whose child is involved with system of care.
- I view my role as an informant. I have been on just about the whole spectrum of mental health including multiple diagnoses, drug abuse, alcohol abuse, as well as a disease. I know a lot and know how to use my knowledge.
- Community partner.
- Having a voice.
- I participate through Youth M.O.V.E. and have attended conferences in the state and nationally. I also have attended the state collaborative. For me personally, with the help from NCFU, I have led my team and shown my future plan to my team.
- Consumer & provider.
- I should learn more about it.
- Consumer & advocate.
- I was, in the past, involved. Now I am no longer.
- As a parent.
- At this point, my son is an adult, so I act more in the role of sounding board, supporter, and consultant.
- I am beginning a nonprofit to support families who face mental health challenges.
- A Certified Family Partner.
- To lead in-services and request what services I think is best for my child.
- I did not have one!
- Director/advocate.
- I feel that I am a positive support for children who are in care.
- Family Partner, pioneer, trainer, mentor, community leader.
- As a partner.
- Until recently I felt my involvement and training as a family partner was advantageous both to myself and the families I served. However, in recent months I have become discouraged and feel disappointed by the politics and personal agendas which have entered into System of Care dynamics in my area. Control of services has become

paramount rather than involving advocates who truly impacted on families they serve. My involvement with families continues as the need and respect for my work ethic is still recognized by families who continue to struggle.

- My family is a recipient of care provided from System of Care. It has been a knowledgeable resource for helping me maneuver through tough situations with local schools and agencies.
- What is "system of care"? If this is a special initiative, I am not aware of it. I came into this survey thinking it an opportunity to comment on the mental health "system" that we are in the midst of trying to navigate.
- I am a family partner who was trained by ParentVoice MHA.
- Community collaborative chairperson
- Team player, facilitator, expeditor, referral source.
- Secretary for Craven, Pamlico, Jones
- As a family partner, I like to encourage staff who attend the training to view the family in a positive light. I have heard many people say you do not understand the families we work with however; I know that if you asked some of the professionals who have worked with my family they would say I was difficult because of something they disagree with that I believe in. ALL families have something to bring to the table, sometimes we just have to look harder than others.
- As parent very helpful.
- I am a community stakeholder.
- I just get information. And I serve on the child collaborative committee here.
- I have been the lead family partner since April 2010; prior to that I was an advocate with another non-profit.
- My role is to assist my son in receiving what he needs to be successful.
- I am a member of the collaborative.
- Very important.
- We help establish goals for our son's IFSP and learn from his physical therapist and other specialists on how to continue to encourage his development.
- I don't think this is what we have, but I advocate and coordinate for the child who lives with me.
- I attended a training about it and learned that, if it were offered locally, he would not be eligible per the criteria set aside to determine eligibility. Also learned that from start to finish the parent would drive the SOC and it was completely voluntary (and mostly unpaid) for the providers who agreed to be part of it.
- I am a caretaker as well as an advocate.
- Usually as a referral or consulting source.
- As a link between the community and the MCO.

Are there any personal accomplishments that you have made as a result of being involved in System of Care or using a system of care approach for you and your family? If so, please describe.

- Assistance in getting IEP.
- When our baby was diagnosed with a severe case of the then-deadliest (recognized) form of SMA, I used my background as a teacher of orthopedically- and multi-handicapped children - primarily to ask the non-supportive neurologist about support groups and to master the internet to search for info and other SMA families. We had access to home health and hospice nurses (both fantastic), birth-3 testing for potential services (our baby didn't live long enough), medical care (we had dropped the maternity coverage), and gas vouchers for medical visits. I became involved with Parent to Parent after our son's death and continue to help as much as possible with referrals of other SMA families and families who have experienced the death of a child/baby from any cause.
- Not used in any way.
- I have been able to see that someone was interested in my son and wanted to help.
- Through the GAL program, the court orders the result.
- My involvement has enabled me to train many in "CFT", also used the system of care to get out information on "crisis intervention team" training for law enforcement, information and signing up people for NAMI "basics" course and NAMI "family to family" course, both of which I teach. It also brought me into the "juvenile crime prevention council" in our area (Carteret county).
- Child family team training (for which I'm certified for 1 and 2) has given me great insight into how much the interaction of concerned persons can solve or alleviate problems, even at our small family group level.
- Our SOC time was over a decade ago, as a family. Since that time, my family, which was very fractured and hurt at the time, has grown very close and caring and loving. Our skills continue to increase re communication and having re-learned to have fun together not just be in chaos (which is over as well!) I have been a paid Family Advocate in my county for 12 years.
- When I got my first apartment, I got involved with a drug dealer in which I got any drug I wanted for free. This lasted for 3 months. Then one day, actually black Friday 2010, I went to spend the day with my mother. That night she tried to commit suicide. Police were called and she was detoxed and put into a psychiatric facility. Right then something clicked in my head and I quit my drugs right then.
- Since being a part of the system of care program, I have been proactive in achieving the goals that I have set for myself. And have learned that you should never give up the fight for gaining your success.
- I have graduated from High School and have entered community college because of RENEW.
- I became a CPSS to do my part to improve the System of Care.
- Going to grad school, public speaking.
- My first career was a result of the system of care.
- Met good people who want to help my child.
- My son has had excellent mentors who have helped him mature and make better

decisions. They also were wonderful support when needed and a repository of information.

- I am a family partner, I have co-taught system of care course at the university, am a member of the mental health planning council, and co-authored system of care interdisciplinary book on system of care.
- Presented at National Conferences and certified as a Family Partner.
- I did not go to jail!
- Improved academically due to after school program, few suspensions, advocacy and leadership skills, provided peer counseling and peer tutoring, involved in wraparound program, better self-control.
- I adopted my 2 daughters about 3 years ago. I don't think I would have been otherwise blessed with them in my life had I not been involved in the System of Care.
- GED and college and own apartment.
- Founder of family-run organization.
- I have witnessed families improve due to our involvement helping them overcome barriers as well as opening doors to services. I also have seen families adopt ways to improve their socio-economic standing by accessing resources we offer to lighten the load in their personal lives. I now work with families who no longer struggle with day to day need for food on the table, and they are armed with and utilize pantry information, free clothing outlets, household items and furniture via FreeCycle. Families are more trusting and reach out when faced with adversity or questions about situations or services They have become more open allowing us to have more in-depth information which allows us to peel back the layers and work on underlying causes to some of the things they struggle with and would otherwise keep them from progressing.
- Yes, when you know more, you do more. I have become a great advocate for my children. This has helped them be more productive in school, as well as it has helped rebuild the relationship with the local school system. The information I've learned through System of Care network has helped us in this way.
- Yes, getting the training and understand now what SOC is for our family. Knowing that our child is the most important entity!
- Funding for school based therapy began in Tyrrell several years ago.
- Work collaboratively with our school FIT team to ensure children's and families' needs are met at school and in the community. Within this year alone, have identified several families who were in crisis and have assisted in creating a multi-disciplinary approach to their care re: physical and mental health, shelter, academics, safety. Have seen increased attendance in the children and job placement, stable housing for some of the families.
- Received referrals and have gained knowledge on community events and programs.
- Working together as team for my child through foster care and adoption.
- Allowed me to address needs and gaps in the community. Allowed me to develop programs to help meet some of the gaps.
- No.
- I live and breathe SOC both in my professional and personal life. To me, the SOC principles are applicable in all aspects of life and help to improve function in all areas.
- Getting a job.

- It has gotten me familiar with the different type of services offered in Washington Co.
- We have learned a tremendous amount about developmental pediatrics and pediatric physical therapy.
- We were involved with CDSA. I am not sure if this is the same thing.
- The closest thing I ever experienced to a SOC was early intervention. That helped us tremendously. All formal supports ended at age 3 as he did not qualify for an IEP based on his diagnosis. He lives in the service gap. Unfortunately, I've met a lot of kids his age and younger who live in that gap here.
- I believe I have helped my family members help overcome some of his weaknesses. I am very much interested in his care. He has become my life. We have had people from the outside that have resulted in unfortunate results.
- I feel I have been able to better serve in my capacity as a service provider by consulting with the System of Care Coordinator from time to time.
- SOC has facilitated the funding of programs to assist the youth of the county that would have gone unmet.

Please check which of the following agencies you are involved with. (You may choose more than 1.)

- 30 Mental Health/Substance Abuse/Developmental Disabilities LME-MCO
- 12 Public Health
- 31 Families
- 25 Family Organization
- 18 Youth
- 18 Youth Organization
- 4 Community Care of North Carolina
- 30 School System
- 14 Social Services/Child Welfare
- 16 Juvenile Justice
- 9 Vocational Rehabilitation
- 17 Service Provider Agencies
- Other agencies in which respondent is involved:
  - I help with Parent to Parent as much as possible.
  - On Coastalcare CFAC
  - National Alliance On Mental Illness (NAMI NC)
  - MHCO
  - Parent Voice
  - National Alliance of Mental Illness (NAMI)
  - Law Enforcement
  - Childhood Development Services Agency of the Blue Ridge
  - CDSA
  - Medical
  - Faith-based organization

Do you participate in your local community collaborative?

- 29 Yes
- 25 No

Do you and/or your family regularly participate in Child and Family Team meetings?

- 25 Yes
- 30 No

If you answered yes to #13, are you given input into the time and place for these child and family team meetings to be held?

- 21 Yes
- 10 No

Have you attended any System of Care or Child and Family Team trainings?

- 27 Yes
- 24 No

Have you ever led/facilitated any System of Care training?

- 16 Yes
- 41 No

Have you taken the Family Partner 101 training?

- 14 Yes
- 43 No

Do the organizations/systems that you are involved with actively work to include families and youth in all levels of System of Care (planning, training, and implementation)?

- 31 Yes
- 20 No

If families and youth are included, please describe how families and youth are involved in System of Care.

- Some involvement in planning, not so much in training.
- I get to go to the child and family team and tell them about my son.
- All throughout the system.
- We collaborate with each other trying to figure out ways to improve the system.
- Becoming and Connected are specifically geared toward enhancing family and youth involvement in systems of care.
- They use the voice of the families and youth in committees and trainings to advocate for services that is needed in the area.
- I have co trained TRANSITION TRAINING, RENEW. and Futures Planning/
- It depends on the LME/MCO, community, county, etc.....Youth MOVE
- Advocacy with Youth M.O.V.E.
- Advocacy w/ Youth M.O.V.E., outreach, input, TA
- We are not treated well. It is frustrating.
- Meetings, seminars, trainings, consultations.
- Often parents are asked to select the time they would like to have a meeting based on the choices presented to them. Usually those choices are what is most convenient for the agency staff.
- NC Families United.
- Monthly support group meetings, SOC trainings.
- Participants, trainers, advisors.

- Given opportunities to share if there are any concerns or needs of the parents.
- Families currently involved are those whom the agencies involved feel benefit their efforts to control System of Care, anyone who differs in methodology or delivery is pushed out and discouraged from future participation.
- Monthly meeting are held in breakout groups. The children are in group with one another and it is led by a trained counselor within System of Care network. The adult group is conducted in the same manner.
- We are involved with every decision and most of the time we are coordinating those decisions. Knowing how to get the services and the best help for their child to get home and have the tools to a better life.
- Decisions and input are always agreed upon by parents and team. Parents are always invited to have input and decision making. The power to change and make changes lies with them—we see ourselves as the support structure.
- It has been a barrier to find active participants to attend Community Collaboratives. For those that are family participants, they do provide input and have a voice regarding services.
- Training and planning.
- Work to develop programs that help families and youth that are dealing with domestic violence issues.
- Advocacy with Youth M.O.V.E.
- Some are invited to meeting and talk to the group.
- We as parents are involved with CDSA providers in helping set goals for our son and work to achieve those developmental goals (cognitive, speech, gross motor, etc.).
- There is no SOC model in place in Watauga County.
- The provider service we are with now does not want to be involved with any services.
- Advisory and planning.
- Development of treatment objectives and goals are family/client driven.

Please describe efforts to recruit families and youth for involvement in System of Care.

- Doesn't happen.
- We recruit Volunteers for our program constantly.
- That's a sore point. I've tried and have not gotten much response or help.
- Very little done by the LME/MCO. I try to get families involved but do not have much success.
- Communicate with members of my support group and on various listservs.
- This is an ongoing effort and has had success recruiting families to participate though have not been able to maintain family involvement with any consistency.
- Telling my story and giving fliers.
- Alliance recruits in person, on the internet, and at community events. Individual family and youth members recruit in various community settings.
- They use trainings and community activities to recruit families and youth.
- We look at youth who are working with NCFU.
- Again, inconsistent.
- Outreach, social media, leadership.

- Public awareness campaigns such as behind the scene.
- Invited to attend resource fair.
- Informative meetings, handing out flyers.
- The nonprofit Success for Children and Families promotes and supports families in involvement in System of Care.
- I have seen some individuals really explore recruitment of new families to participate and I have seen staff look within the agencies to recruit someone out of the office that can "fill the role".
- People recruit us! We get referrals from all systems.
- Community outreach, support groups, advertisements.
- Right now recruitment is a revolving door with very few families being sustained; rather there exists a revolving door with our families losing interest.
- Community meetings and word of mouth.
- Our neighbors, our church members that have children with mental disabilities.
- Collaborative is looking for a parent rep.
- We haven't really had to recruit as we have an abundance of needs with families.
- Recruitment efforts are ongoing. They are done through various ways of communication regarding emails, collaboration among other stakeholders. Stipends are offered to families and youth who participate.
- Churches, providers, law enforcement, mental health agencies.
- Flyers are put out into the community and school when programs are being held.
- Families should have to be recruited for involvement in System of Care; it should be an expectation of every family raising a youth with behavioral, emotional, and/or mental health needs that are multi-system involved that the systems will work collaboratively to assist the family in identifying their strengths, needs, and long-term goals and developing a family driven/youth guided, individualized plan for accomplishing their goals.
- Info is out there, and we use the resources.
- By inviting youth to the meeting.
- There hasn't been any, to my knowledge.
- There is no SOC model in place in Watauga County.
- Very leery to involve families or youth. It does not seem to work out.
- Invitation through provider agencies, schools, and the community.

Please describe some ways in which you feel that the agencies and organizations with which you are involved could benefit from more family and youth involvement.

- Would really like an age-appropriate way to include young children in meetings.
- I'm currently helping only Parent to Parent as I can—helping other families in NC faced with a diagnosis of SMA and participating in a panel of three moms who have lost children at an early age in a childhood class at Appalachian State University.
- Organizations working together for the good and success of the families. Most organizations tell the families what they need to do (to deserve the help) rather than wrap services around the family to help them succeed.
- It could give further insight to the dynamics of what is needed to assist families

involved in the system.

- We have to get families of young children to regard system of care as useful for them to attract them to the meetings and other activities. The agencies and providers seem to always be busy with constant change and large numbers of consumers to treat. I am a failure at this part!
- The agency (and the rest of us) needs to get the word out there (newspapers, radio, and television) to raise interest and to show the gains to be achieved by working together.
- It is very hard to know what it is like for families/youth unless you hear directly from them....and more than one. Everyone is different and everyone's experience is different.
- The information that the family and youth have is the 'real deal'...it is what is really happening in their homes. And, it is the feedback about services and supports. Having this information available along with both attending collaborative meetings, etc., keeps agencies and organization keenly aware of what works and what does not. And, from the real life experiences, the collaboratives are so much richer in finding their direction on how to best serve family and youth.
- More involvement means more people to help; more people to help means less problems and more understanding, which in the end, crime rates will fall.
- They already have involvement from youth and families.
- We need more money for Youth MOVE.
- Education, awareness, integration of services, creation of new services, and their growth. Listen to youth.
- Youth culture and unique needs.
- They would get a better sense of empathy for families who are struggling.
- In our County, there are family partners connected to the collaborative.
- I serve as a Family Partner now so I am speaking from the voice of families I currently serve. Each one of us has something to bring to the table, especially families and youth. They are the experts on themselves. Agencies could save time and sometimes money by empowering the family or youth to share whether an intervention will work for them or not. Families are asked, but it often feels like it is expected for them to comply with the suggestion on the table, so it does not feel like family choice.
- Healthier family relationships, training, education, empowerment, family-oriented system changes, Person-centered services and treatment plans, family-provider partnerships, educated youth, increased college attendance.
- In training for services available to them.
- System of Care can only improve if families are the true leaders who influence the philosophy. They are the ones on the frontline experiencing the struggles and success. There is no more important voice in this process than those in the trenches. Some of our professionals in no way know what it feels like to actually live and breathe this journey each and every day. They have no idea what it feels like to be on this roller coaster and that you can't just get off. The professionals who have not dealt with a special needs child would never be able to build a better mouse trap without significant input from the families they attempt to serve.
- More involvement would result in more productivity in the local communities, better outcomes for families in distressed situations needing advice or more intensive services. It would help as an advocate and buffer between other community and

government agencies that may be involved with families. Overall, individuals and families would benefit from the positive productivity, which is a real result of the education they take away from it.

- Not currently involved with agencies but one is true shared parenting with foster parents. From what I have seen, foster parents do not wish to have this involvement. The same with most agencies, they may be using the SOC, but they don't engage the families as such.
- Need student-parent input on collaborative.
- The benefits would be in less turnover of staff with families. There is involvement, but the turnover is so frequent that by the time a worker has developed a schedule, they leave, and another worker has taken over. No consistency—which is really what the families lack to begin with.
- Families and youth perspectives are totally different from stakeholders so it is important to hear their voice.
- More birth families actively involved with treatment.
- I think that organizations need to attend both sections 1 and 2. The agencies need to see success from other family members and youth.
- All need to have SOC training.
- More family and youth involvement would lead to more prevention and awareness.
- Make more of an impact.
- Get more involved with the kids in ISS at school.
- More input.
- Perhaps creating a network of families dealing with very similar kinds of health/ medical issues? (We do have Parent-to-Parent, which is how I heard about this survey.)
- The family support agency with which I am involved is all about family and youth involvement. The best support I have had locally is through family support groups. We do what we can to support one another, suggest resources, share similar experiences, etc.
- It is all money now. There have been sooo many cuts and reduced hours. They only seem to act on the HIPAA laws, which in my opinion are dangerous.
- Through our Quality Improvement Process.
- Improve the perception or reduce the stigma of receiving services.

Please describe ways in which agencies and organizations could better recruit families and youth to participate in System of Care or help families and youth to feel more comfortable participating.

- I don't know what they're doing now so can't suggest anything.
- Offer to help the families succeed rather than telling them what they need to do.
- Tell us that they exist.
- If the LME/MCO, health dept., DSS, schools and providers would inform families of the system of care and then we set up meetings to give them reasons to join, maybe that'd work.
- As above, also bringing the families receiving child and family team meetings into the system of care meetings to pass on their thoughts and knowledge.
- Time and location working for the family. Or, making transportation available.

- Go to rallies such as LGBT.
- I feel that they do a good job with recruiting.
- Actually show an interest when we present to the state collaborative or the planning council. The adults look bored when we are speaking.
- Integrate outside of mental health. Educate the public and raise awareness.
- Have food (community events).
- Go to schools.
- Have more trainings geared to youth and family involvement.
- Encourage families during regular CFTs to participate. Youth that have experienced any level of success during the CFT should be encouraged to participate. Develop a relationship with the family with genuine respect and share details about expectations all along so the family can be prepared for the tasks.
- Agencies and organizations can better recruit families and youth by promoting the organization and offering numerous methods to learn about programs that are available.
- Ask families what they need and what will encourage them to participate; meet the basic needs of families that would reduce barriers to participation; show tangible benefits and results of family/youth participation.
- More trainings.
- Many agencies don't tell their families about other organizations who foster family participation and certainly not family-run committees where opportunity to meet families who can advocate, advise, or guide them through System of Care.
- Email list, hosting public events, linking up with medical providers where allowed. Connecting with schools, and athletic associations, and other community partners. Churches where allowed, billboards, etc.
- Connect with those that are out there to help families such as ParentVoice, which provides the families with the training needed for their child.
- To look at the service not as a punitive thing, but as a helpful resource that could enhance their family life.
- Social networking.
- Incentives, express that it is an open forum, there are no judgments placed on people that attend and the information they share.
- More information to families, free training.
- Continue to bring awareness and addressing needs and gaps.
- By advertisement.
- By getting the youth more involved.
- More information would be very helpful. If they have programs which would involve special needs persons, it would be nice to know about it.
- Well, to begin with, the local service agencies could implement a System of Care model. However, I feel the local agencies are getting stretched to the max as is, and if this is mandated to them, without any type of monetary compensation and additional personnel, we will not see this happen.
- Act like they care for the child and their families. They have been told to treat families like robots.

- Have a community/agency training and explain what SOC is all about, how the process works, and how youth and families can benefit. Arrange something at the local Recreation Centers.
- Make it a part of the family orientation information.

Do you work with a Family Partner?

- 15 Yes
- 37 No

If you answered yes to # 23, rate the benefit of having a Family Partner on your team: Average of 4.3.

- 1 None
- 1 Some
- 0 Moderate
- 4 Significant
- 10 Extensive

Please rate how much progress your community/ System of Care has made towards creating, expanding, or generating the following: (You may skip any that you are unfamiliar with).

	None	Some	Moderate	Significant	Extensive	Don't Know	Average
Home & community-based services & supports	8	9	12	10	6	4	2.93
Individualized, wraparound approach to service planning and delivery	8	9	12	10	5	4	2.89
Family-driven & youth-guided services	7	9	11	9	9	4	2.84
Family & youth involvement in the planning & delivery of their own services	8	11	10	8	8	4	2.93
Use of evidence-informed & evidence-based approaches	5	7	9	11	8	6	3.25
Political & policy-level support for SOC at the state level	11	7	11	5	5	7	2.64
Political & policy-level support for SOC at the local level	11	9	10	3	5	7	2.52
Partnerships with provider organizations, management in provider organizations, MCOs, etc.	6	5	15	9	4	8	3.00
Partnerships with civic leaders & other key leaders	11	7	10	7	3	7	2.58
Ongoing training, TA, & coaching	8	9	10	8	6	5	2.88
Capacity for ongoing training, TA, & coaching	9	7	9	8	2	10	2.57
Ongoing training on evidence-informed & evidence-based approaches to support high-quality & effective service delivery	8	10	9	8	5	6	2.80

Are trainings offered by agencies and organizations that you or your child are involved with open to family members and youth?

- 28 Yes
- 14 No

What trainings have you accessed that have been beneficial to your understanding/ implementation of System of Care?

- SOC training (4 respondents)
- CFT (3 respondents)
- IEP training and workshops (2 respondents).
- Trauma and brain development
- I participated in train the trainer.
- Family Support Network Trainings.
- Collaborative training.
- Changes in CAP Waiver.
- W.R.A.P.
- Mental Health 101
- Leadership training.
- NCFU trainings, RENEW and Transition Training
- PSS training, MH first aid, personal MH trainings.
- National SOC conferences.
- Resource fairs.
- Parent/child seminars.
- Child and family team 1, and 2---Heart to Heart, Family Partner 101
- GIFTTS - an old Guilford County wraparound training
- Any available trainings that are necessary.
- I am registered to attend Family Partners 101 and Parental Training. These classes are not being offered at the agency that placed my children in foster care but an outside agency.
- MCTI CFT 200 and 300 series, Family Partner training for NC certification.
- Community.
- I have accessed and completed every training offered in Mecklenburg.
- All of the SOC 200 series as well as the other speakers invited to the monthly ParentVoice meetings.
- These are ongoing at Collaborative meetings.
- Leadership.
- Some from Family Support Network/Parent-to-Parent. Not specifically for "System of Care"
- I attended a training about it and learned that, if it were offered locally, he would not be eligible per the criteria set aside to determine eligibility. Also learned that from start to finish the parent would drive the SOC, and it was completely voluntary (and mostly unpaid) for the providers who agreed to be part of it. I have no knowledge of other trainings on this subject offered locally.
- No trainings offered often. If trainings are offered, usually hear at the last minute or too far away.
- Ones sponsored by the LME

What other resources have you accessed that have been beneficial to your understanding/ implementation of System of Care?

- My only experience with any kind of 'system of care' came in 1997; I don't know that anything I was able to access is still pertinent.
- ?
- Community resources.
- The system of care manual.
- The help of agencies and providers that are the mainstay of our sys of care meetings.
- Working with ?
- Most came from outside the system of care.
- Leadership.
- I was just told I can get help at North Carolina Families United. In the 3 weeks that I have known them I have learned more and feel supported than at any other time.
- Info from mentor.
- Sitting on boards and committees, North Carolina Families United Website, National Federation of Families Website/
- Representation in IEP and DJJ meetings. Also, training in helping me understand and be more active with my child's IEP.
- PowerPoint presentations at Collaborative meetings.
- NC Autism Society, Buncombe County. Not specifically for "System of Care"
- None - why research it if it is not an option for my family? That would just make me mad.
- I don't know of any resources. No one seems to care.
- By attending the collaboratives.
- Community collaboratives.

Please indicate whether the following items have been challenges/barriers or strengths/supports to System of Care implementation in your area.

	Strength	Challenge	Don't Know
Treatment providers	13	26	12
Support from supervisors	16	18	16
Commitment from administrators	11	19	19
Commitment from families	20	15	13
Commitment from youth	22	13	14
Anxiety/fear about changing to a system of care approach	7	27	16
Momentum	11	22	16
Adequate funding/resources	4	36	9
Collaboration	23	20	8
Supporting policies/procedures	16	21	14
Funding for implementation and services	5	37	10
Advocacy	25	19	5
Training availability	20	21	8
Funding for training	7	27	14
Fidelity after training	6	18	23
Time for supervision	10	17	20
Supervisors trained in System of Care	15	16	15
Understanding/willingness to put family-driven practices in place	17	19	8

Additional comment: We have a new MCO and these are issues that we just don't know yet.

What are other strengths of System of Care or things that are working in your area related to System of Care that were not listed above?

- Parent to Parent are definite strengths!
- It is not in place. Only in severe cases where Juvenile Justice is involved.
- There is not much available here.
- Collaboration.
- RENEW and my care.
- Youth MOVE, any & all training.
- Youth M.O.V.E.
- Leadership.
- Just the child teams.
- System of Care Coordinator but no identified family partner in county.
- A willing community to do things differently for children and families.
- A mentor.
- Family resource center, youth leadership organization.
- Communication, relationship, and team building.
- Can't think of any at the moment.
- We have a great partnership among various stakeholders within the counties I serve.
- Sharing of community events and programs; speakers that provide additional knowledge regarding services
- Clarification of Services, Access to Leadership? Youth M.O.V.E., etc.
- No one seems to care. Things were better in the 1980s than they are now.
- Access when needed.

How do you define System of Care?

- I would define it as a collaboration of myriad services in the community for the purpose of maximizing the potential for families faced with some sort of special need(s).
- System of Care is services that are available to families that wrap around them, are parent/family driven and help them to succeed.
- Caring for the child by a team approach.
- Holistic comprehensive collaborative support for children and families across all services/agencies.
- A system that is designed to assist the family/youth with mental health needs within the community.
- By thinking" together we can better do the job".
- Community collaboration to provide improved care to children and families with children‘s problems, both health and behavioral.
- The totality of systems working together to benefit youth and their families.
- That it is about the collaboration between family and agencies and between agencies themselves. Families are seen as full partners at the business or meeting table. It is essentially a strength-based approach for developing a strong family-centered plan as well as a movement in the community, region, and state.
- A place where you’re not judged and helped for ailments that most people CAN’T/ WON’T understand.
- My definition of System of care is that they provide a positive environment for youth

and families. And also collaborate with other agencies to involve people that there are other ways to stand up for yourself and promote self-confidence.

- Having a team come together to support you and what you need.
- Support network.
- When all agencies work together to help a family.
- System of Care means the various organizations that make it possible for my son to meet with psychiatrists and psychologists who help him manage his bi-polar diagnosis.
- A strength-based family-driven approach of partnering with youth and families who face mental health, substance abuse, and the juvenile justice system to reach successful and effective outcomes.
- Integrated and coordinated community resources which support children and families to meet their needs based on their strengths.
- Hope that they cure.
- System of Care is an organized network of services and supports that helps children with serious emotional disturbances and their families get what they want and need.
- Helping those with disabilities.
- An attitude and way of doing business as related to family and youth care services through the Mental and Emotional Health Systems.
- A great community resource for families with children that are at-risk or near the at-risk stage for various reasons.
- SOC is for the Child/Youth and their family to better the life of the child, Family Driven and Youth Guided, Child and Family Team, Natural Supports, Collaboration, Community Based Service, Culturally and Linguistically Competent, Individualized. Strengths Based, Persistence, Outcome Based and Data Driven. Oh yeah! IF only this would be so. Money commands most things.
- Coordinated supervision of services in the county for clients.
- Collaborative approach to assisting families with community and health resources.
- Framework that offers great resources to children and families who are at risk of serious emotional or behavioral challenges. SOC is utilized to fill gaps and connect services to those in need.
- A collaboration of mental health professionals, doctors, substance abuse professionals, school, church, and law enforcement, as well as community organizations to share information regarding community events and trainings as well as make informed decisions regarding improvements for the local community.
- A way to let families and youth get help for youth, but they take the lead as much as possible.
- Valuable to the community.
- A System of Care is a comprehensive network of community-based services and supports that are organized to meet the challenges of families who are involved with multiple agencies/services. System of Care is not a service or a program—it's a practical way of partnering with families to meet the needs that they identify as important.
- Helping people that are in need Mentally or substance abuse.
- I am assuming it is any agency or network that supports children and families with health-related challenges.

- All supports, whether private or government, which help families with special needs members, to improve their lives or situations.
- A system of care brings together everyone working with a child in need, including the family, so that services for that child and family are maximized while family requirements remain manageable, reducing duplication of services, insuring no service gaps, and increasing child and family well-being.
- It all depends on your wealth. It is very expensive to take care of a child with autism. Everything now has spiraled downward.
- A method of finding out what works best for a family or individual in order to promote positive growth and development.

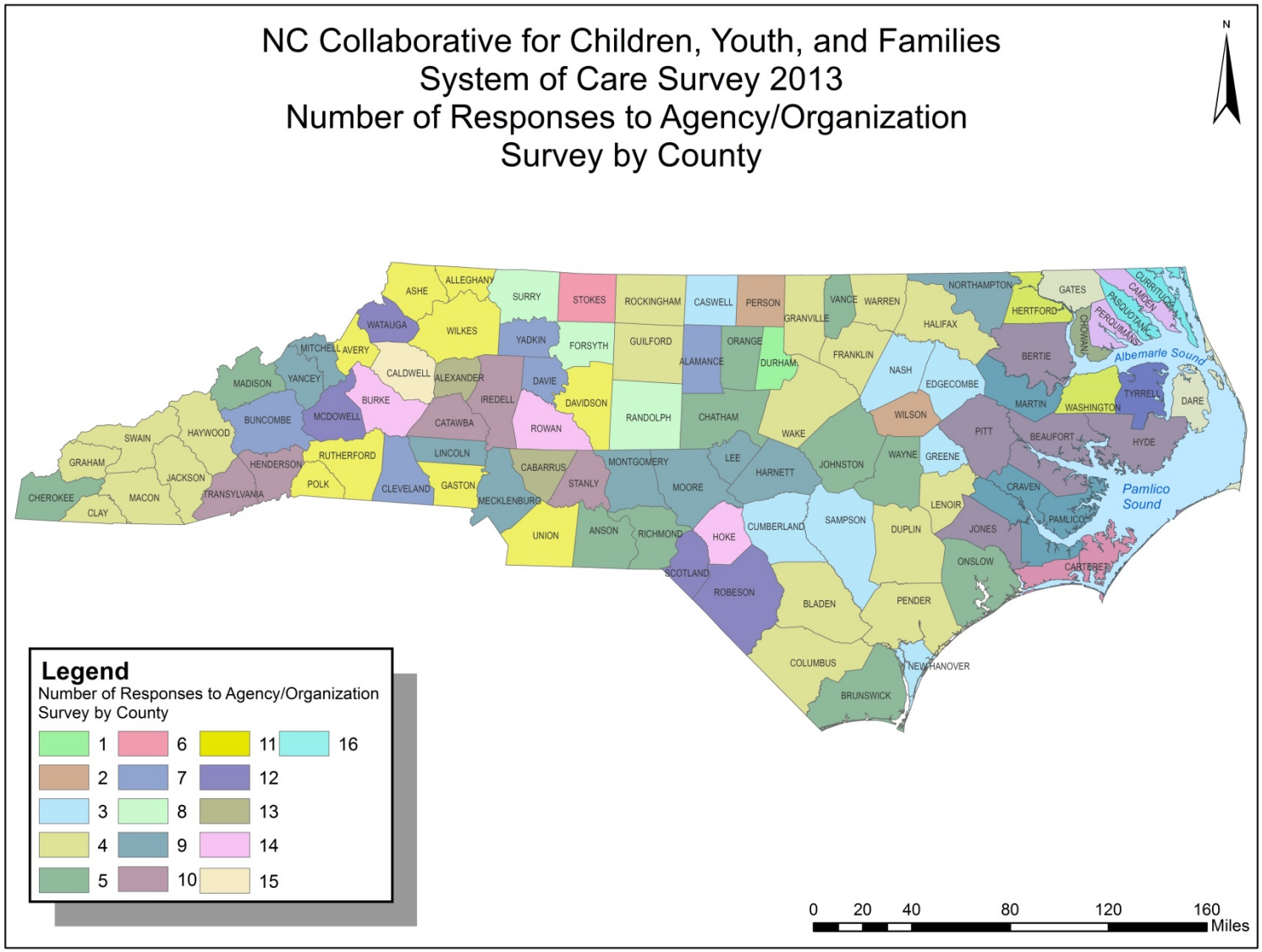
Additional comments about System of Care:

- I think it's an essential proposal in many ways and hope the funding can be made available!
- Wish it was more available to families in our area that really need it.
- I believe that by working together, our children and youth will find more successful treatment of both health and mind problems, with agencies and providers spending less and providing better treatment.
- I believe it should be a major aim of all communities to collaborate in order to do the best for our troubled children and families.
- If I were not trained in the field, I don't know how much of this survey I would understand. I am truthfully not sure how much I understand it even though I have training and I go to meetings.
- I would be in a hospital if it wasn't for NCFU and RENEW, Youth Move.
- We work in teams to plan and implement a set of services for each child with SED and those teams include family advocates and usually we try to get someone from MH, especially when we have CFT meetings. We are involved with JJ and DSS and very much involved with the court system. We have a great relationship with our judge.
- Great resource, I feel it should get more support to make a larger impact in the community. It has really helped me keep my two boys in the school system, by providing me the support and education I needed to understand and interpret law better, know my and my children rights, and to help me voice my concerns and get results so that my children can be educated young men and not simply overlooked.
- Getting the agencies away from the PCP focus and working on the “One child One plan” for this is what families will benefit from after services. Also helping train those natural supports and focus on the family after services.
- Families should not have to be recruited for involvement in System of Care; it should be an expectation of every family raising a youth with behavioral, emotional, and/or mental health needs that are multi-system involved, that the systems will work collaboratively to assist the family in identifying their strengths, needs, and long-term goals and developing a family-driven/youth-guided, individualized plan for accomplishing their goals. System of Care is a philosophy not a program. In my area, during the period of our SAMHSA SOC grant, it was viewed more as a program, something to be “enrolled” in. Now that the grant money is no longer in our community, it appears that many service leaders and providers feel that the SOC is “over” and not a recommended best practice for a way of providing support to families

and youth.

- I'm interested to know more what this means. We work closely with CDSA and with doctors at Brenner Children's Hospital but could probably benefit from broader resources for children with medical difficulties.
- What is it?
- With the exception of Watauga County Schools and the Special Olympics program, there are few supports for children with special needs—no extracurricular or after-school activities, no summer camps or summer programs.
- My child gets many services, and I have sought help and training from Parent to Parent many times with success, but I don't know really what SOC is. And we do not have it. Sorry I could not answer these questions better for that reason.
- SOC does not exist in all areas of the state. It's a nice model in theory, but there are significant implementation challenges at present, at least for western NC.
- NC needs insurance for autism. HIPAA laws need to be revamped. It's hard to be an advocate and not break HIPAA laws.

Appendix H


NC Collaborative for Children, Youth, and Families
System of Care Survey 2013
Number of Responses to Agency/Organization
Survey by County
N
ALLEGHANY
ASHE
SURRY
STOKES
ROCKINGHAM
CASWELL
PERSON
VANCE
WARREN
NORTHAMPTON
GATES
CURRITUCK
CAMDEN
PASQUOTANK
PERQUIMANS
CHOWAN
HERTFORD
GRANVILLE
HALIFAX
WATAUGA
WILKES
YADKIN
FORSYTH
GUILFORD
ORANGE
DURHAM
FRANKLIN
NASH
EDGECOMBE
BERTIE
Albemarle Sound
MITCHELL
AVERY
CALDWELL
ALEXANDER
DAVIE
ALAMANCE
MADISON
YANCEY
BURKE
IREDELL
DAVIDSON
RANDOLPH
CHATHAM
WILSON
MARTIN
WASHINGTON
TYRRELL
DARE
BUNCOMBE
MCDOWELL
CATAWBA
ROWAN
WAKE
PITT
BEAUFORT
HYDE
SWAIN
HAYWOOD
GRAHAM
RUTHERFORD
LINCOLN
CABARRUS
MONTGOMERY
LEE
JOHNSTON
WAYNE
GREENE
HENDERSON
JACKSON
POLK
CLEVELAND
GASTON
STANLY
HARNETT
CRAVEN
Pamlico Sound
CHEROKEE
MACON
TRANSYLVANIA
MECKLENBURG
MOORE
LENOIR
CLAY
UNION
ANSON
RICHMOND
HOKE
CUMBERLAND
SAMPSON
DUPLIN
JONES
PAMLICO
ONSLOW
CARTERET
SCOTLAND
ROBESON
BLADEN
PENDER
COLUMBUS
NEW HANOVER
BRUNSWICK
Legend
Number of Responses to Agency/Organization
Survey by County
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
0
20
40
80
120
160
Miles