North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities and Substance Abuse Services Michael F. Easley, Governor H. David Bruton, MD, Acting Secretary

MEMORANDUM [1]

To: Area MH, DD, SAS Program Directors and Child and Family Coordinators, County DSS Directors, Chief Court Counselors, Youth Academy Directors

From: Martha Kaufman, Child and Family Mental Health Section
Chief Chuck Harris, Child and Family Services Section Chief,
DSS Donn Hargrove, Assistant Secretary, DJJDP Michael
Schweitzer, Assistant Secretary, DJJDP

Date: February 1, 2001 Subject:
“At-Risk” Children’s Program

INTRODUCTION The Divisions of MH/DD/SAS and Social Services, and the Department of Juvenile Justice and Delinquency Prevention are pleased to provide a description of the new “At-Risk” Children’s Program to serve children and adolescents with Serious Emotional Disturbances in the state of North Carolina. This memo serves as follow-up to the September 15 memo from James Edgerton and the New Beginnings Trainings that occurred in November and December 2000. The “At-Risk” Children’s (ARC) Program has grown from the former Willie M. Program, the Carolina Alternatives Program, the work of the Futures Committee, as well as studies from implementation of Center for Mental Health Services System of Care demonstration sites in our state. The implementation of this statewide program is an exciting yet daunting undertaking. *At the outset, we want to emphasize what success will look like in this program: it will be our collective ability to divert (and to clearly document these diversions) children from going into DSS custody, into Training Schools (Youth Academies), and into State Hospitals inappropriately, i.e., because they could not receive community-based mental health services.* We are looking forward to working with each of you on the implementation of the ARC program and appreciate any feedback that you could provide as to the mechanics of the implementation. This memo will outline the basics of the program to date. You will find attachments as referenced.

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[1] This document has been formatted, *without any change to original language,* by Martha Kaufman on 5/7/2020 for use by the State Collaborative and other entities seeking information regarding the origins of the SOC infrastructure in NC. Words highlighted in color are those used in an internet search and cannot be removed from the current document. MCK

BACKGROUND In July of 2000, the North Carolina Legislature created a new funding category for children with serious emotional disturbances. The "At-Risk" Children's (ARC) program was designed with the goal of serving children at-risk of institutionalization or other out-of- home placement. While this program was being implemented, the State legislature also created another innovative and much needed program known as the *Children's Residential Treatment Program* with the goal of increasing the amount of available funding for residential treatment (as an alternative to institutionalization) for children and youth with serious emotional disturbances. As a result of the legislature creating these two new programs, the former Willie M. program was dissolved, eliminating the services entitlement along with that program's infrastructure and grievance procedures. The legislature also mandated funds for the group of children that were served through the former Willie M. Program/Eligible Violent and Assaultive Children's Program. The legislature created these two programs with the intent of increasing services to a broader group of children than were served through the former Willie M. Program and Eligible Violent and Assaultive Children's Programs.

IMPLEMENTATION PLANS The legislature provided the Division of MH/DD/SAS with a set of guidelines upon which to build the new programs. Child and Family Services within the Divisions of MH/DD/SAS and Social Services, and the Department of DJJDP conformed to these guidelines when designing ARC's program implementation **through a comprehensive System of Care approach**. The Department of Health and Human Services has chosen to merge the two programs into one functioning program known as the "At- Risk" Children's program. Given the similarity of the target populations and eligibility criteria, this streamlining will result in system integration, eliminate redundancies in operational management, and provide a more responsive care system for children "At-Risk" and their families. A copy of the legislation creating the programs is attached (Attachment # 1), along with a 'crosswalk' of the legislative requirements for the new program with the implementation template (Attachment #2). The Child and Family Mental Health Section's Child and Family/At-Risk Workgroup (comprised of Area Program, private provider, and **family advocacy representatives**) worked diligently with us on this plan. The legislature mandated Memoranda of Agreement (MOA) at the local and State levels between the Department of Health and Human Services/ Area Mental Health Programs and both the Division of Social Services and the Department of Juvenile Justice and Delinquency Prevention. These MOA's will serve as the basis for interagency cooperation and collaboration **through local Community Collaboratives** in the delivery of comprehensive mental health services to children served through the ARC program. Each party is required to sign the local level MOA prior to the release of funds to the Area Programs for the new program. We will continue to work with all participants to refine these MOA as a meaningful tool to promote collaboration across all child-serving agencies. MOAs will be refined each year and will require new signatures.

The implementation of this program will be accomplished through a System of Care treatment approach. “System of Care” is a treatment philosophy that has gained nationwide acceptance as a Best Practice model in the delivery of service to children with serious emotional disturbances and their families. A System of Care is a comprehensive spectrum of mental health and other necessary services and supports, organized into a coordinated network to meet multiple and changing needs of children (with specific mental health needs) and their families.

Based on two core values, System of Care is: 1) Child and Family-Centered: There is a commitment to *adapting* services to the child and family’s needs. providing services that enhance the personal dignity of the child and family maximizing child and family involvement and self-determination in treatment planning and care delivery. 2) It is Community-Based: The community is the primary locus of services/supports. Local System of Care management, decision making responsibility and accountability rest at the community level. There is additional pertinent information regarding System of Care, and through a series of regional training initiatives and State level technical assistance to local communities, the specifics of the SOC philosophy of treatment as the template for implementation will be relayed.

As discussed in the recent New Beginnings training events, the complex and changing needs of children with serious emotional disturbances and their families often require the services of multiple agencies and other support resources. Consistent with a System of Care approach, our goal is to establish one core service team and one comprehensive service plan with each participating child and family to reduce duplication and increase access to and integration of services. Therefore, the actual treatment/services delivered to children/families through the At Risk Children’s program will be planned and coordinated though ***Child and Family Teams.*** These service teams will consist of the *core/front-line* agency staff, the family, and other stakeholders directly involved in the treatment of the child who is “At- Risk” and his/her family. The Child and Family Team will collaboratively make treatment and service decisions and deliver those services, in partnership with the family, for individual children in the program. **Case Managers and families are the lead** members of the Child and Family Team. Please see the attachment entitled *What is a Child and Family Team* (Attachment #3) for a fuller explanation of the working of this group.

In order for front-line agency staff, the family, and other stakeholders in the individual Child and Family Teams to succeed, program level decision-makers (i.e., those who make local program and policy decisions for their agency or organization) must collaborate. Therefore, **each Area Program will also be required to spearhead the development and implementation of a *Community Collaborative***. This group will consist of ***program level decision-makers*** from local human services agencies, (DSS, DJJDP, Area Programs), private providers, along with families, family advocacy representatives and other community stakeholders. **Area Programs, DSS, DJJDP and families must have representation** on the Community Collaborative per legislative mandate. Representation from LEAs (local schools), Guardian ad Litem Offices, community organizations, the faith community and other interested parties is strongly recommended. **The Community Collaborative will serve as the body that supports and oversees the functioning of their community's Child and Family Team's and the development of their local System of Care**. A core responsibility of all participants in the Community Collaborative will be to **focus on outcomes**, i.e., those that will define our collective success: *to divert (and to clearly document these diversions) children from going into DSS custody, into Training Schools (Youth Academies), and into State Hospitals inappropriately, i.e., because they could not receive community- based mental health services.* It will evaluate the aggregate service needs of a given community and collaboratively share resources and decision-making with the local agencies/providers to ensure an adequate continuum of appropriate services and supports in the catchment area. The Community Collaborative will also have a very important function of developing and maintaining a waiting list for services indicated (but not funded) for children in the ARC program. **Members of the Community Collaborative must be empowered by their respective agencies/organizations to make decisions regarding funding and service provision.** Please see the attachment titled *What is a Community Collaborative* (Attachment #4).

Area Program, DSS and DJJDP staff should work closely with each other, with families and family support/advocacy organizations to develop the Community Collaborative and are encouraged to build upon existing collaboratives, unifying local efforts and avoiding duplication. **A State Collaborative has been developed, comprised of representatives from DMH/DD/SAS, DSS, DJJDP, families, family advocates and other stakeholders. This collaborative effort will address policy concerns, oversee and serve as a resource to Community Collaboratives to promote the successful implementation of local Systems of Care.**

TRAINING The System of Care represents an innovative approach to the delivery of mental health services in North Carolina. In an effort to increase awareness of the System of Care principles and educate policymakers, administrators, providers, advocates and families regarding the SOC operational process, the State will organize a series of training initiatives. These training programs will be made available to interested and involved parties at the regional level. The State also will provide ongoing technical assistance designed to aid in the statewide System of Care implementation. The series of training workshops will be conducted this Winter and Spring and will be advertised to all SOC representatives including families, advocates, DSS, DJJDP, Area Programs, private providers and other interested parties. To date, the series will include events addressing: 1) The Organization and Functioning of Child and Family Teams and Community Collaboratives 2) Family/Professional Partnerships in the treatment children who are At-Risk, and their families 3) Case Management Training emphasizing the philosophical basis of conducting a Child and Family Team. Additional information regarding this training series will follow.

TRANSITION FROM WILLIE M. TO "AT-RISK" From the outset, Area Programs, as well as all other stakeholders in the treatment of children At- Risk, and their families, must understand that the ARC Program is *not* the Willie M. Program. There are several key differences: ♦ The ARC Program must serve a much broader population than the Willie M. Program. ♦ The ARC Program is *not* an entitlement program. There is a finite amount of At Risk funding available for services leading to the creation of services waiting lists that will be maintained and monitored by the Community Collaboratives. The Community Collaboratives will work cooperatively to prioritize children waiting for indicated services. Area Programs will participate in the decision-making process; however, the final decision will be made by the Community Collaborative. While a child may be eligible for ARC services, s/he may not receive them due to funding limitations. Children eligible for Medicaid are entitled to medically necessary services that are funded through that program. However, the program will provide certain services that are not Medicaid funded. These services, although available to all children in the ARC program, are not an entitlement. ♦ The ARC program will provide clinically appropriate and medically necessary services. Services (including Case Management) delivered through the ARC program must meet the State medical necessity criteria as outlined in the Level of Care document for children's mental health services. Utilization Review/Management will serve as an integral program component at both the local and

State levels and will be based on the Level of Care document. This applies to services billed to Medicaid *or* ARC. ♦ There will only be one rate for a given service delivered through the ARC program which will correspond to the Medicaid rate, *regardless of payment source*. ♦ There will be children in the ARC program who are given priority status for services because they are designated as legislatively mandated *"Priority Populations"* ♦ There is no separate appeals procedure for the At Risk Children's program. The separate appeals procedure that was in place for the Willie M. Program was repealed by the legislature. Area Program, Division and Department appeals policies and procedures remain in effect to deal with Medicaid and non-Medicaid appeals. The Community Collaboratives cannot take on responsibility for or take the place of Medicaid appeals.

By taking the above-mentioned steps, we believe that the ARC program will serve a much broader population with appropriate and medically necessary services. The System of Care will call upon partner agencies, community organizations and most importantly families to work collaboratively to devise innovative treatment/habilitation plans that will utilize informal/natural resources to a much greater degree than in the past while actively involving the entire community in the care of children At-Risk, and their families. The aims of the program are to help families access appropriate and timely mental health services and support systems within close proximity to home, decrease inappropriate placements into DSS custody, to Training Schools (Youth Academies), to State Hospitals, and promote greater independence with support from existing community resources.

SCREENING AND ASSESSMENT The legislation upon which the ARC program is based called for behavioral screening of all children at risk for out-of-home placement or institutionalization. We interpreted this to apply to children at-risk of inappropriate placement in DSS custody, Training School (Youth Academies) or State Hospitals due to lack of appropriate mental health services. To comply with this segment of the legislation and identify children before they become inappropriately institutionalized, we have initiated screening programs specific to DSS, DJJDP and the Division of Mental Health.

Children who are in DSS legal custody (regardless of current physical custody) will be screened with a battery of instruments available to the local DSS agencies. Other children involved with DSS, but not in custody may be screened at the local DSS agency's discretion. If screened positive (i.e., the child needs behavioral health services) using these very sensitive instruments, they will be referred to the local Area Program for the “Preliminary Assessment and Determination of At-Risk Status” process.

For children involved with the juvenile justice system, a slightly different process will be implemented. When an intake is scheduled with a local DJJDP Court Counselor, a Needs Assessment (developed by DJJDP) will be conducted. If a child screens positive using this instrument, s/he will be referred to the local Area Program for the “Preliminary Assessment and Determination of At-Risk Status process. Children may be recommended by the local Area Program and from any other referral source for At Risk services and supports. A family, school, community agency or organization, religious organization, private mental health provider or other interested members of the community may, at any time, refer a child for a “Preliminary Assessment and Determination of At-Risk Status.” The following process will be used for *all* referrals:

Within 30 days of referral: ♦ Completion of the “Preliminary Assessment and Determination of At-Risk Status.” – Area Program personnel, the referring party, and (as possible) the parent or guardian will jointly assess and determine the child’s eligibility, i.e., they will go through the eligibility criteria decisions together. This process must occur for any child referred, including those already served by the Area Program. ♦ Completion of the AOI Part I (Resiliency Assessment.) for all children new to the At Risk Program ♦ Completion of the CAFAS for children new to the Area Program ♦ See Attachment #5 for specifics regarding eligibility criteria. ♦ *If the child is **eligible**:* ♦ He/she will be assigned an Area Program case manager who will work jointly with the parent/guardian and the referring party to complete a Preliminary Service Plan (i.e., the standard DMH service plan): ♦ The Area Program case manager, referral party and parent/guardian (and others as available) work together as the initial/core Child and Family Team to identify and authorize immediate/priority service needs, e.g., case management, etc. ♦ Complete an initial crisis plan to divert the child from institutionalization. ♦ Initiate the Family Information Packet – provide the parent/guardian a copy of the SOC Parent Handbook, copies of all documents completed during the screening, assessment and service plan process. ♦ Develop a plan for convening a full CFT within 30 days (Area Program case manager and parent/guardian work together, as a team, in this process). ♦ *Within 30 days of admission into the ARC program:* ♦ The Child and Family Team meets and conducts a strengths-based needs/preferences assessment, completing the Outcomes Assessment Instrument (AOI) Part II. ♦ The Child and Family Team will then develop a full ARC program Service Plan to address the identified needs/preferences of the child and family. Information from the Preliminary Service Plan is updated and incorporated, including the crisis plan. ♦ Add materials to the Family Information Packet – provide the parent/guardian with copies of the ARC program Service Plan and additional documents from each agency, with case management assistance as needed to obtain and/or discuss content.

All children referred for admission into the ARC program must meet the ARC program eligibility entry criteria. Subsequently, referral does not guarantee eligibility. The Area Program is still obligated to serve children/families who are not eligible for the ARC program as they always have. Medicaid services continue to be an entitlement for those who are Medicaid-eligible. Area Program policies re: treating clients who are insured, uninsured or underinsured will remain in effect.

ELIGIBILITY A listing of the eligibility criteria for the ARC is attached (Attachment #5). **The State Collaborative has developed these program criteria to meet the legislative demands**. You should begin enrolling children under the new eligibility criteria immediately. There have been some confusing messages regarding the eligibility of the former Willie M. class members that we will take this opportunity to address. These children will remain eligible for the program up to 18 months (as of July 1, 2000). Their eligibility will then need to be reassessed per the “At-Risk” eligibility criteria. They may or may not qualify for the program at that point, since there is no longer an entitlement for services. Again, former Willie M. class members will not be granted automatic eligibility for the At Risk Children’s program as of July 1, 2000.

Services delivered to these children will be subject to the same utilization review that all services in the program receive. Children and their families may have already been enrolled in the program based on previous criteria provided to the Area Programs. These children and families will also remain eligible for service for a period of time up to 18 months. At that time, their eligibility will need to be reassessed (see below.) Children will need to have their eligibility for ARC services re-evaluated annually. In an effort to incorporate the eligibility process into existing record systems, Area Programs will be using the child's mental health "Form B" date (i.e., the date of entry into the Area Program) as the date for re- evaluation of ARC eligibility.

In order to promote continuity of care as we transition the ARC program into the existing system, a child's initial eligibility is valid for up to 18 months from the point at which h/she entered the program. If a child's mental health "Form B" date come less than six (6) months after his date of initial ARC eligibility, re-evaluation by the Child and Family Team can wait until the next year's "Form B" date. However, if the child's "Form B" date comes more than six (6) months after his initial eligibility date, re-evaluation must occur by the Child and Family Team on the subsequent mental health "Form B" date. For example:

Enters AP System ARC Eligible ARC Re-Evaluation Due ("Form B" date) Child A 1-1-01 3-1-01 1-1-02 Child B 1-1-01 9-1-01 1-1-03 The date of initial ARC eligibility for all former Willie M. class members is 7-1-00 and they will need re-evaluation based on the above system and "Form B" date just as any other participating child.

DOCUMENTATION Children in the ARC program will be required to have an annual AOI (Assessment Outcome Instrument) coinciding with the mental health "Form B"/Re-evaluation date. As described above, an AOI will be completed upon admission to the ARC program. A Preliminary Service Plan should be completed at the time of entry to identify immediate/priority service needs, including case management and a crisis plan, with the referring party and (as possible), the parent/guardian*. This plan must be in place before billing can occur*. Within thirty (30) days of eligibility a more **comprehensive plan should be completed with the full Child and Family Team**. Please refer to the DMH/DD/SAS Records Manual for full explanation of rules regarding Service Plan timing. To ensure clinical integrity, ARC program Service Plans will need to be re-done on the child's mental health "Form B" date, along with the eligibility re-determination and AOI. The Child and Family Team will complete this. This is similar to the former Willie M. program's "THP date." If a child becomes eligible for the ARC program more than 30 days prior to his mental health "Form B" date, a full update of the ARC program Service Plan will need to be done on the "Form B" date. The new ARC program. Service plan had been developed and is under review at this time. You will be notified when it is available and it will be posted on the DMH/DD/SAS Web Page. Completion of the AOI is an integral part of the service planning process. Part I of the AOI will be used as a Resiliency assessment to help determine eligibility for the ARC program and so will be completed for all children undergoing eligibility determination. If a child is eligible for the program, the AOI Part II will need to be completed within 30 days as part of the overall strengths-based service planning process. The ARC program Service Plan should be built around the strengths, needs and preferences of the eligible child and family and utilizing information gathered during the completion of the AOI Parts I and II.

AREA PROGRAM RESPONSIBILITIES IN THE AT-RISK CHILDREN'S PROGRAM Area Programs will perform an integral leadership role in the ARC Program. There are numerous key functions that Area Programs must provide in order to ensure that the ARC Program operates successfully. These include, but are not limited to: 1. Staff the local Community Collaboratives. Area Programs personnel *may chair the groups until June 1, 2001 to facilitate more rapid start-up*. After that time, the role of chairperson must rotate. The requirement that the chairperson role not be held by an Area Program staff member is due to the need for At Risk services to operate as a collaborative and comprehensive venture in the community rather than a one-agency initiative. 2. Oversee the clinical integrity of the treatment delivered through the "At-Risk" Children's Program. 3. Work with the local Community Collaboratives to maintain a services waiting list for eligible children. 4. Work with the local Community Collaborative to document the number of children diverted from inappropriate DSS custody, Training School (Youth Academies), or State Hospitals. 5. Assume the responsibility for reporting the status of the waiting list and the number of children diverted from institutionalization to the State Office within 2 working days (as needed). 6. Assume the responsibility for relaying budget issues to the Community Collaborative relative to the services waiting list. 7. Act as a liaison with the State Office of Child and Family Services in the Division of MH/DD/SAS. 8. Ensure that newly ARC-eligible children are entered into the State MIS system. 9. Ensure that a notification of eligibility status is sent within 10 working days of the "Preliminary Assessment and Determination of At-Risk Status" to all parents/guardians and referral sources for children and families referred to the program. 10. Provide parents/guardians of children newly eligible for the "At-Risk" program with ♦*System of Care Handbook for Parents* ♦*Family Information Packet* (see Attachment # 6). 8. Ensure that each eligible child benefits from a results-oriented Child and Family Team. 9. Ensure that the Child and Family Teams completes the Assessment Outcome Instrument (AOI) in a timely and appropriate manner for each eligible child. 10. Ensure that Child and Family Teams complete and update Service Plans in a timely and clinically appropriate manner for each eligible child and his/her family. 11. Ensure that each child's eligibility for the " At Risk Children's" Program is reassessed on an annual (first year up to 18 months) basis referencing to his/her mental health "Form B" date. 12. Ensure that detailed and functional Crisis Plans are in place and updated at least every 6 months for eligible children and that a copy is given to the eligible child's parent/guardian for the Family Information Packet. 13. Develop and submit a yearly training plan to the State Office regarding the Area Program's continuing education needs/plans and implementation regarding System of Care.

14. Ensure that the "Preliminary Assessment and Determination of At-Risk Status" is a joint

and collaborative process, completed in a timely manner, i.e., within 30 calendar days. These functions may all be fulfilled by a System of Care or “At-Risk Children’s” coordinator, or may be fulfilled by a variety of Area Program personnel. In either case, each Area Program must ensure that all functions are operating efficiently.

WAITING LISTS AND PRIORITY POPULATIONS The ARC program has a limited budget. This is a significant difference between the ARC program and the former Willie M. program. The legislature has appropriated a given amount of funding for the ARC program and Area Programs will be allocated their share as determined by a formula derived by DMH/DD/SAS in collaboration with the North Carolina Council of Community Program’s identified workgroup. We do not know how many children will meet the new At Risk criteria or whether the allocation of funds will be sufficient to provide appropriate and medically necessary services to all “At-Risk” children/families for non-Medicaid services. There will be no limit to the number of children eligible for services; and *children who meet the ARC eligibility criteria should be served on a ‘first come/first served’ basis while At Risk funds are available*. However, budget constraints may determine the need to prioritize amongst those eligible children if/when At Risk funds become insufficient to meet the service needs of eligible children. Medicaid-eligible children continue to be entitled recieve appropriate and medically necessary services. There will be specific services that the ARC program will fund that are not Medicaid billable. These will not be considered an entitlement; consequently, the ARC- eligible child covered by Medicaid could still be subject to waiting lists for non-Medicaid covered services due to ARC budget constraints. This has created the need for Community Collaboratives to carefully monitor the availability of funds over time in order to develop and maintain waiting lists for necessary services to track and document any unmet service needs. It will be incumbent upon the Collaboratives to make decisions regarding prioritization for services.

The ARC program was conceived by the legislature to divert children from institutionalization, and in an effort to prevent families from feeling forced to give up custody to DSS in order to access needed mental health and residential treatment services. In order to achieve this legislative goal, the ARC program has established “Priority Populations” for necessary services. They are as follows:

Priority #1) Children in the former Willie M. program who were certified as class members prior to January 22, 1998 (see clarification below)

Priority #2) Children who are at imminent risk of being inappropriately placed in: ♦ DSS custody ♦ Training School (Youth Academy) ♦ State Hospital due to lack of necessary mental health resources

Children in these groups are to be given priority status for appropriate and medically necessary services by the Community Collaboratives; e.g., ARC funds should not be authorized for children outside the Waiting List while there are children on the Waiting List. Children in the former Willie M. program will be considered highest priority to promote transition and continuity of care to the new program but only if they continue to meet ARC Program eligibility criteria and they were certified as class members prior to January 22, 1998. That was the date that the Willie M. program was released from court supervision and became the program for Eligible Violent and Assaultive Children. Children in the former Willie M. program/EVAC program are automatically eligible for the ARC program through July 1, 2001. After that time, they will need to be re-evaluated for eligibility as per their mental health "Form B" date. They will only be given priority status within the program if they were certified under the lawsuit (prior to January 22, 1998).

The Division of MH/DD/SAS is expected to report to the legislature on the number of children diverted from inappropriate DSS custody, Training School (Youth Academy) or State Hospital as a result of implementation of the ARC program. It will be extremely important to keep accurate documentation of these accomplishments. It will also be important to keep accurate and up-to-date waiting lists for the different services. We *all* need this information to clearly demonstrate unmet needs to the legislature in order to continue and increase program funding. In addition, we will be using the waiting lists to assess the availability of services in the various regions of the State as we plan, develop and implement a network of services/ support systems for families of children with serious emotional disturbances throughout North Carolina.

Again, ARC is not an entitlement program. Services will be provided only as long as funding is available. Waiting lists will be established based on a child's status as a member of a priority population. If s/he is not a member of a priority population, the local Community Collaboratives will make the decision regarding prioritizing children for services, considering all available resources. IMPLEMENTATION OF THE NORTH CAROLINA SYSTEM OF CARE FOR THE "AT RISK CHILDREN'S" PROGRAM. In order to effectively implement the ARC program, there are some basics that must be addressed and reported (by Area Programs) to the DMH/DD/SAS in a timely manner. These basics will be included in each Area Program's performance agreement beginning in July 2001.

JANUARY 2001 (As covered in the November and December *New Beginnings* Trainings)
♦ **Begin meeting *now* with members of your Community Collaborative in order to prepare for effective implementation of the ARC program.** Among the important issues to discuss are:

- Membership
- Who will chair
- Information necessary for

effectiveness

- How your local process will work
  - How you will educate each other about your particular roles and/or mandates ♦

Develop a plan to ensure that private insurance, Medicaid or Health Choice are payors of first resort all eligible children. ♦ By January 15, Submit Area Program's Utilization Review plan to the Program Accountability Section of the DMH/DD/SAS. (Attention Jim Jarrard – Jim.Jarrard@ncmail.net). The plan must utilize the State Mental Health Level of Care Criteria for all "At-Risk" **children** and all services rendered. **FEBRUARY 2001 ♦ By February 1, begin enrolling children (per the processes described previously) based on their CAFAS scores, out-of-home placement risk, DSM IV diagnosis, and Multi-agency involvement.** DMH/DD/SAS will provide you with the Resiliency Screening Form (AOI Part I) in the next weeks. When you receive it, please begin completing this form for children being screened for the program and send forms to: Data Operations Branch of the Division of Mental Health, Attention: Latonia Toms

Note that the scores on the AOI Part I (Resiliency Assessment) will not be used to determine eligibility until **March 1, 2001.** DMH/DD/SAS will provide explicit instructions as to when and how to begin using these scores to determine eligibility. The forms must be completed and on children screened in order to determine appropriate cut-off scores for eligibility. **Again, use only the CAFAS scores to determine eligibility between now and March 1, 2001.** AOI Part I (Resiliency Assessment) forms for both eligible and non-eligible children should be sent to the above address and copies should be made for Area Programs. Children who have been deemed eligible during the period from July 1, 2000 until present will continue to be ARC-eligible. They will be subject to the yearly review of eligibility status, as will all children in the program. **♦ By February 1, local level MOA between Area Programs and local DSS agencies must be signed. By February 15, state and local MOA between Area Programs and DJJDP must be signed. All MOAs must be signed annually by July 1 thereafter (content may change).** The signatures will be monitored during Division Audits beginning in February 2001. **♦ By February 1, core members of the local Community Collaborative must be identified and submitted to the State Office of Child and Family Services in the Division of Mental Health**. (Attention Ginny Lofton: 919-571-4900, Ginny.Lofton@ncmail.net) The membership **must** have representation from Area Programs, Families/Advocacy Groups, Local DJJDP and Local DSS Agencies. Additionally, representation should also be sought from local educational agencies, Guardian Ad Litem offices, Public/Private Health Agencies, Community Organizations, Faith Community etc. **♦ By February 1, all Area Programs must submit the name of a program coordinator to the Child and Family Services Section of DMH/DD/SAS.** Please submit the name of your designee to Ginny Lofton at the above e-mail address/ phone number**. MARCH 2001 ♦ Begin using the AOI Part I (Resiliency Assessment) to determine ARC program-eligibility**

consistent with processes described previously.

FINANCIAL AND SERVICES REPORTING Information regarding allocations, budgets, rates and reporting requirements for the ARC Program will be sent under separate cover.

The Division of MH/DD/SAS, the Division of Social Services, and the Department of Juvenile Justice and Delinquency Prevention are very excited about the new At-Risk Children's Program and the promise it holds for enhancing community-based treatment for a broad population of children with serious emotional disturbances and their families in our State. The General Assembly has given us a window of opportunity to begin developing a System of Care that addresses the needs of children and families in an efficient/effective, and most importantly, humane and family-centered manner. We must all work together in order to succeed in diverting (and clearly documenting these diversions) children from going into DSS custody, into Training Schools (Youth Academies), and into State Hospitals inappropriately, i.e., because they could not receive community-based mental health services. We look forward to working collaboratively with you, with families, advocacy groups, as well as many others in the community who are interested in the well- being of children and families in our State. If there are additional questions, please feel free to call or write the DMH/DD/SAS Child and Family Services Section RSMs (Regional Service Managers), the DJJDP Regional Administrators, and/or the DSS Regional CPRs (Children's Programs Representatives). Much more information is to follow.

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Enclosures

SPECIAL PROVISIONS **Bill Number: H1840 Section Number: 11.21**

SERVICES TO CHILDREN AT RISK FOR INSTITUTIONALIZATION OR OTHER OUT-OF-HOME PLACEMENT Section 11.21.(a) In order to ensure that children at risk for institutionalization or other out-of-home placement are appropriately served by the mental health, developmental disabilities, and substance abuse services system, the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall do the following with respect to services provided to these children: (1) Provide only those treatment services that are medically necessary. (2) Implement utilization review of services provided. (3) Effective immediately: a. Eliminate formerly court-mandated Willie M. or Eligible Violent and Assaultive Children Program administration, infrastructure, categorical funding designation, and eligibility determination process at the State and local level; b. Identify savings realized from elimination of Program administration and infrastructure at the State and local level; c. Adopt the following guiding principles for the provision of services:

1. Service delivery system must be outcome-oriented and evaluation-based. 2. Services should be delivered as close as possible to the consumer's home. 3. Services selected should be those that are most efficient in terms of cost and effectiveness. 4. Services should not be provided solely for the convenience of the provider or the client. 5. Families and consumers should be involved in decision making throughout treatment planning and delivery. d. Implement all of the following cost reduction strategies:

1. Preauthorization for all services except emergency services. 2. Levels of care to assist in the development of treatment plans. 3. Clinically appropriate services. 4. State review of individualized service plans for all children served to ensure that service plans focus on delivery of appropriate services rather than optimal treatment and habilitation plans. (4) Collaborate with other affected State agencies such as the Office of Juvenile Justice and the Administrative Office of the Courts, and with local departments of social services and area mental health programs to eliminate cost- shifting and facilitate cost-sharing among these governmental agencies with respect to the treatment and placement services. Section 11.21.(b) The Department shall submit a progress report on implementation of this section not later than February 1, 2001, and a final report not later than May 1, 2002, to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the Fiscal Research Division. Section 11.21.(c) G.S. 122C-3(13a) is repealed. Section 11.21.(d) G.S. 122C-112(14) is repealed.

Section 11.21.(e) Part 7 of Article 4 of Chapter 122C of the General Statutes is repealed. This subsection applies to petitions for contested case review filed on and after the effective date of this act.

Bill Number: H1840 Section Number: 11.19

CHILD RESIDENTIAL TREATMENT SERVICES PROGRAM Section 11.19.(a) The Department of Health and Human Services shall establish the Child Residential Treatment Services Program. The Program shall be implemented by the Department in consultation with the Office of Juvenile Justice and other affected State agencies. The purpose of the Program is to provide appropriate and medically necessary residential treatment alternatives for children at risk of institutionalization or other out-of-home placement. Program funds shall be targeted for non- Medicaid eligible children and may also be used for Medicaid- eligible children. Program funds may also be used to expand the Child Mental Health Systems of Care Project. The program shall include the following: (1) Behavioral health screenings for all children at risk of institutionalization or other out-of-home placement. (2) Appropriate and medically necessary residential treatment placements, including placements for youths needing substance abuse treatment services and for specialized populations such as deaf children, children with serious emotional disturbances, and sexually aggressive youth. (3) Multidisciplinary case management services, as needed. (4) A system of utilization review specific to the nature and design of the Program. (5) Mechanisms to ensure that children are not placed in department of social services custody for the purpose of obtaining mental health residential treatment services. (6) Mechanisms to maximize current State and local funds and to expand use of Medicaid funds to accomplish the intent of this Program. (7) Other appropriate components to accomplish the Program's purpose. (8) The Secretary of the Department of Health and Human Services may enter into contracts with residential service providers.

Section 11.19.(b) The Department shall not allocate funds appropriated for Program services until a Memorandum of Agreement has been executed between the Department and other affected State agencies. The Memorandum of Agreement shall address specifically the roles and responsibilities of the various departmental divisions and affected State agencies involved in the administration, financing, care, and placement of children at risk of institutionalization or other out-of-home placement. The Department shall not allocate funds appropriated in this act for the Program until Memoranda of Agreement between local departments of social services and area mental health programs, and the Administrative Office of the Courts, and the Office of Juvenile Justice, as appropriate, are executed to effectuate the purpose of the Program. The Memoranda of Agreement shall address issues pertinent to local implementation of the Program. Section 11.19.(c) Notwithstanding any other provision of law to the contrary, services under the Child Residential Treatment Services Program are not an entitlement for non-Medicaid eligible children served by the Program.

Section 11.19.(d) The Department of Health and Human Services, in conjunction with the Office of Juvenile Justice and other affected agencies, shall report on the following: (1) The number and other demographic information of children served. (2) The amount and source of funds expended to implement the Program. (3) Information regarding the number of children screened, specific placement of children, and treatment needs of children served. (4) The average length of stay in residential treatment, transition, and return to home. (5) The number of children diverted from institutions or other out-of-home placements such as training schools and State psychiatric hospitals. (6) Recommendations on other areas of the Program that need to be improved. (7) Other information relevant to successful implementation of the Program. The Department shall submit a progress report on implementation of the Program not later than February 1, 2001, and a final report not later than May 1, 2002, to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the Fiscal Research Division.

LEGISLATIVE REQUIREMENTS SOC Implementation

Early Identification: ♦ Behavioral health screens ♦ Preliminary MH assessments ♦ Uniform applications, eligibility criteria & assessments ♦ Preliminary behavioral health screens by local DSS, DJJDP, Area programs, private providers ♦ “At Risk” assessments through Area Program + Referral Party + Parent/Guardian

Service access without reverting to DSS custody ♦ Children not eligible for Medicaid are eligible for residential and non-residential services with At-Risk funds ♦ Proactive crisis planning and ongoing care through Child & Family Teams ♦ DSS At-Risk case management

Services that are: ♦ Outcome-oriented ♦ Evaluation-based ♦ Close to home ♦ Effective ♦ Cost efficient ♦ Clinically appropriate ♦ Medically necessary ♦ Treatment/Service plans through Child & Family Teams ♦ Integrated resources from agencies, community & family ♦ Use of AOI for assessment and outcomes ♦ DMH MIS to track outcomes ♦ Levels of Care to ensure clinically appropriate/ medically necessary services ♦ Utilization Review to ensure efficiency

Build local service capacity/ resources ♦ Community Collaboratives assess, coordinate, and maximize resources across agencies & community supports ♦ Use waiting list data to assess service needs and promote new resources ♦ Area Program system coordination ♦ Direct Provider Enrollment

Agency collaboration ♦ MH/SA/DJJDP/DSS - shared resources & accountability ♦ State Collaborative & MOAs ♦ Community Collaboratives & MOAs ♦ Cross-Agency, Provider, Community, Family training and technical assistance

LEGISLATIVE REQUIREMENTS SOC Implementation

Maximize funds & resources ♦ Community Collaboratives combine & integrate resources & services, blend funds across agencies ♦ State Collaborative promotes & develops policy, special waivers, and integrates resources across agencies

Family/consumer involvement ♦ Family Support/Advocacy builds family participation & partnership ♦ Area programs ensure family involvement in Child & Family Teams and Community Collaborative ♦ Portable Family Information Packet ♦ Child/Family Section ensures family involvement in State Collaborative

Multidisciplinary case management ♦ Child & Family Teams led by Case Manager and Family ♦ Priority populations in MH, DSS, DJJDP ♦ MH and DSS case management

Attachment 3

WHAT IS A CHILD AND FAMILY TEAM?

A Child and Family Team (CFT) is the service team for an individual child and is comprised of the caregiver, all of the service providers involved with the child and family, informal supports and others as identified by the family involved. The primary goal of the CFT is to “wrap” the child and family with services and supports to the extent that children can remain in the least restrictive environment and as close to their homes and communities as possible. In efforts to achieve this, the CFT model seeks to unify providers and families in an equal partner relationship with shared responsibility and accountability for service planning, treatment interventions and strategies, and outcomes.

A CFT is in many ways similar to existing Treatment Teams that already function in the service of children with serious emotional disturbances. Treatment Teams were mandated through the former Willie M. program and many Area Mental Health Programs used them to treat other children with “high-end” needs. The main differences between the CFT and a Treatment Team is that CFT’s utilize a much higher level of family involvement in treatment. Families are partners in care of their children and so are included in every step of treatment planning and delivery. Natural resources are also more highly stressed in the CFT. Families are encouraged to enlist help from a the full spectrum of supports that exist for them within their own communities. Services delivered by a CFT are come from a strengths perspective. Strengths are sought out and built upon. CFT’s are not Area Program entities. They are extensions of the Community Collaboratives formed around individual children and families to meet their individual needs.

Each child enrolled in the At Risk Children’s Program will have an initial Treatment/Habilitation Plan developed by their individual Case Manager and CFT in partnership with the family. Appropriate and medically necessary services outlined by the plan will be delivered as funding permits. Linking, monitoring, and evaluating the plan are also the responsibility of the Case Manager. In terms of expected roles of the team members, these are individually defined on each service plan, as goals and strategies will differ based on the unique strengths and needs of the child and family and responsibilities of individual providers, which may be determined in part by their agency requirements. Bringing all the players involved with the child and family to the table to assist in the creation of a plan ensures that “everyone is on the same page” working toward the same goals, and the support of the family, as well as each other, through the treatment process. This, in turn, eliminates duplication of services and conflicting services, and facilitates communication and consistency across the board.

How do these approaches fit together? There is an interdependent relationship between the Community Collaborative and the CFT. The CFT members rely upon the support , direction and authority of the Community Collaborative in order to carry out their goals. The Community Collaborative members rely upon the CFT’s to know what is working and what is not on a systems basis. Both need the other to be able to move forward, to inform each other as to changes that need to be made at systems and individual levels of care, to identify where gaps are in the systems based upon services used or available to (or not available to) individual children and families. It is this information exchange that allows for a dynamic process that supports families and systems alike.

Attachment 4

WHAT IS A COMMUNITY COLLABORATIVE? Community Collaboratives (CC) are groups of representatives from multiple child-serving agencies, families and community stakeholders who work together to address and plan around common concerns regarding the well being of the community’s children and youth with serious emotional disturbances, and their families. These teams are different from existing interagency program committees in that they go beyond dealing with individual child issues to address issues and provide oversight on the *system and program* levels as well. Ideally, this group is made up of decision making agency directors, supervisors, and/or direct care staff from mental health, juvenile justice, social services, and education, family members and family advocacy organizations and health/medicine. Naturally occurring and informal resources such as interested community members, non-profit organizations, and members from faith communities are included as well. In a System of Care approach, the primary purpose of such a coalition is to promote and enable the delivery of outcome- driven, comprehensive treatment and service plans that incorporate services and supports offered from a variety of public and private providers. The Community Collaboratives are essential to the System of Care and are involved with the management and quality improvement of the system including the facilitation of information exchange, shared accountability in the delivery of effective, efficient, and culturally competent services, and promoting access to comprehensive services. As a group, they aid in identifying service gaps through a needs assessment process and in filling those gaps through the use of shared resources including services and funding. They are responsible for supporting and monitoring the status of Child and Family Teams, including addressing barriers that may be encountered by those teams. They ensure that child-serving staff from related agencies as well as other stakeholders are full participants in training activities to facilitate continuity of care and reduce fragmented and/or duplicative services. Memoranda of Agreement oftentimes will aid in defining some of the parameters under which the CCs operate. The North Carolina "At Risk" Children's Program will utilize a System of Care philosophy of treatment. Community Collaboratives will be required to be in place in all Area Program catchment areas. In addition to the functions delineated above, they will be required to take on one very important additional function. The Community Collaboratives will be charged with developing and maintaining the waiting list for services for eligible children. They will have to develop an understanding of the Legislatively mandated Priority Populations for services in order to accomplish this task. Area Mental Health Programs will be staffing these Collaboratives and will be responsible for ensuring that they are kept up to date on budget issues as they relate to the "At Risk" Children's Program.

1) Placed out of the home or at imminent risk of out-of-home placement, as evidenced by any of the following: ♦ Utilizing or having utilized acute mental health crisis intervention in the past year or

intensive wraparound services in order to maintain community placement; ♦ Having had 3 or more state hospitalizations in the past year or at least 1 hospitalization of 60 continuous days; ♦ Having had DSS substantiated abuse, neglect or dependency in the past year; ♦ Having been expelled from 2 or more daycare or pre-kindergarten situations within the past year;

♦ Having been convicted of a felony or 2 or more serious misdemeanors in juvenile/adult court or being currently placed in a youth advocacy program (training school), prison, juvenile detention center, or jail - any within the past year; ♦ Other **AND** 2) Presence of a DSM IV diagnosable mental, behavioral or emotional disorder. **AND** 3) Presence of severe functional impairment that substantially interferes with or limits his/her role or functioning in family, school, or community activity.

DETERMINED BY CAFAS SCORE OF 90 OR A CAFAS SCORE OF 60 WITH AT LEAST ONE DOMAIN SHOWING A SCORE OF 30. **AND** 4) Presence of an extreme level of psychosocial risk determined by a composite score on the Resiliency Assessment of the AOI (Part 1). CUTOFF SCORE ANNOUNCED 3.01.01 **AND** 5) In need of services from more than one child serving agency (e.g., Mental Health, DSS, DPI/Schools, DJJ, Health Care, other community organizations/ providers). This could include children with significant/serious chronic health conditions.

FAMILY INFORMATION PACKET The Family Information Packet (FIP) is meant to function as a bridge between the child/family and the array of services that they may be receiving. One of the most frequent complaints regarding mental health services is that children and families are subjected to multiple evaluations/assessments at each step of their treatment. The FIP is intended to alleviate this problem as much as possible. Families will be provided with copies of relevant information from their child’s chart by participating agencies. They will be able to give this information to other service providers when requested and thus put a stop to the process of having to retell their story over and over to each new provider. It is also meant to be a method of family empowerment. Families will be treated as trusted allies in their child’s treatment and thus able to provide needed information without having to rely upon professional staff to relay appropriate historical/evaluative material.

Included in the FIP will be*:

- Area Program admission assessment - The child’s THP - Psychoeducational testing (will need to be current within the last 3 years) - Special Educational Plans (IEP etc...) - Psychiatric Assessment (if available) - Discharge Summaries from Psychiatric Hospitalizations (if applicable) - Discharge Summaries from prior treatment facilities (if applicable) - DSS Reports (if applicable) - Juvenile Court Reports (if applicable) - Neurological Evaluation (if applicable) - Speech/Language Evaluation (if applicable) - Other appropriate information

Also included in the FIP will be a *System of Care Family Handbook*. This will serve as a guide for families trying to navigate their way through the System of Care. It will provide support for families and help them to maximize their advocacy efforts.

> * Some materials may not be “re-released.” Area Programs and other Community Collaborative participants may need to assist families/guardians in obtaining these materials. Case managers should be prepared to review FIP information with families/guardians as needed.