Agreement
Between the North Carolina
Department of Health and Human Services
And
Department of Juvenile Justice and Delinquency Prevention
And
Administrative Office of the Courts
And
Department of Public Instruction

Regarding Comprehensive Treatment Services Program for Children at Risk for Institutionalization or Other Out of Home Placement

This Agreement is made and entered into as of the date set forth below, by and between the North Carolina's Department of Health and Human Services, Department of Juvenile Justice and Delinquency Prevention, Administrative Office of the Courts, and the Department of Public Instruction.

Whereas, the Department of Health and Human Services is mandated by law, Session Law 2001-424, Section 21.60 as re-written in SB 163 Section 1(a) and Section 1(b) to establish the Comprehensive Treatment Services Program (CTSP) for children and adolescents at risk for institutionalization or other out-of-home placement, in consultation with the Department of Juvenile Justice and Delinquency Prevention, the Department of Public Instruction, and other affected State agencies, and

Whereas, the Purpose of the Program is to provide appropriate and medically necessary residential and nonresidential treatment alternatives for children and adolescents at risk of institutionalization or other out-of-home placement; and

Whereas, Program Funds may also be used to expand a system-of-care approach for services to children, adolescents and families statewide.

Therefore, the signatories of this agreement recognize that a system-of-care approach should form the basis for the use of Comprehensive Treatment Services Program. The terms of this agreement shall be in effect FY 05-06 through FY 07-08.

Guiding Principles & Plan

Signatories of this agreement agree to the following guiding principles expressed in SL 2001-424, Section 21.60 and SB 163, Section 1(a) and 1(b),:

- Deliver services that are outcome-oriented and evidence-based.
- Deliver services as close as possible to the child's home.
- Select services that are most efficient in terms of cost and effectiveness.
- Involve families and consumers in decision making throughout treatment planning and delivery.
- Provide services that are not solely for the convenience of the provider or the client.

Furthermore, signatories of this agreement, through their participation in the State Collaborative, agree to collaborate in the planning and recommending of policies to the

various departments, divisions, and affected state agencies, to accomplish the following functions:

A. Coordination & Collaboration among State Agencies regarding CTSP:

1. Involve families in planning and decision making at the state, regional and local level.
2. Identify participants in the State Collaborative who can effectively represent the priorities and concerns of their respective sections/departments/agencies.
3. Identify resources that are regionally accessible and meet the needs of special populations.
4. Develop guidelines regarding community collaborative, and child and family teams.
5. Develop procedures, to the extent permitted by law, for sharing information about specific children and adolescents among agencies.
6. Encourage community-based services and supports that cross existing agency boundaries and funding streams.
7. Develop mechanisms to maximize Federal, state and local funding options.
8. Develop and recommend policies governing cost-sharing, braiding funds, and flexible funds.
9. Develop and recommend policies to eliminate cost shifting.
10. Develop a common database, to the extent permitted by law, to assist in the report to the legislature.
11. Collaborate in the implementation of rules, policies, and guidelines developed as a result of Section 4 of SB 163, that affect CTSP children and adolescents.
12. Share cross agency/family/community training and technical assistance to promote best practices and outcomes-based accountability.
13. Work with parents and families to educate the public on the needs of children and adolescents.
14. Jointly appear before legislative committees regarding CTSP.

B. Evaluation & Outcomes

• DHHS, in conjunction with DJJDP, DPI, and other affected agencies, will report on the following information as identified in Section 21.60(g) as re-written in SB 163 Section 1(a):

1. The number and other demographic information of children and adolescents served.
2. The amount and source of funds expended to implement the [CTSP] Program.
3. Information regarding the number of children and adolescents screened, specific placement of children and adolescents including the placement of children and adolescents in programs or facilities outside of the Child's home county, and treatment needs of children and adolescents served.
4. The average length of stay in residential treatment, transition, and return to home.
5. The number of children and adolescents diverted from institutions or other out-of-home placements such as Youth Development Centers and State psychiatric hospitals and a description of the services provided.
6. Recommendations on other areas of the [CTSP] Program that need to be improved.
7. Other information relevant to successful implementation of the [CTSP] Program.
8. A method of identifying and tracking children and adolescents placed outside of the family unit in group homes or therapeutic foster care home settings.

• DHHS, in conjunction with DJJDP, DPI, and other affected agencies, shall submit a report to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services and the Fiscal Research Division as required by legislation.

•Assess parent/family involvement in child and family teams.

Department of Public Instruction

The Department of Public Instruction agrees to:

1. Participate in the State Collaborative.
2. Encourage personnel in Local Education Agencies (LEAs) to participate in local community collaborative.
3. Encourage participation in child and family teams.
4. Collaborate with other departments in training efforts to address system of care as the methodology for accomplishing CTSP mandates, including using federal funds for this purpose.
5. Encourage superintendent(s) and director(s) of charter schools to sign, and to participate in the implementation of the local MOA for the Comprehensive Treatment Services Program.
6. Ensure that all children and adolescents who have disabilities and who are in need of special education, related services and supports are identified, located and evaluated. This includes acting to refer the child for a comprehensive evaluation in all situations when a school system has reason to suspect that a child might be eligible for services and supports.
7. Provide information and/or training to administrators, support services staff, alternative learning program staff, and exceptional children staff in the school and school system regarding their roles in the implementation of CTSP for students who are at risk of institutionalization or other out of home placement.
8. Work jointly with DHHS to provide structure, information, and guidance to local schools and school systems to assist them in working with local management entities, area authorities and county programs to provide services that are billable to Medicaid, CTSP, Health Choice, etc.
9. Collect DPI relevant data to provide information to DHHS for the report to the legislature on the program information outcomes listed in Section 21.60(g) as re-written in SB 163 Section 1(a) and Section 1(b).

Administrative Office of the Courts

The Administrative Office of the Courts recognizes that the following programs and staff have direct contact with children and adolescents and their families and/or directly impact children and adolescents and their families:

- District Court Judges
- Youth and Family Drug Treatment Courts
- Guardian ad Litems

- Child Custody Mediation Program
- Family Courts Programs
- Juvenile Court Improvement Project

The Administrative Office of the Courts agrees to:

1. Participate in the State Collaborative.
2. Encourage judges to hear evidence from the child and family team when considering the need to order certain residential and program placements and to engage in other appropriate consultation, that does not involve ex-parte communication, with a party to a pending proceeding.
3. Encourage a representative of the Guardian ad Litem program to be a member of each child and family team when there is a pending abuse or neglect case involving that child.
4. Encourage a representative of the Youth and/or Family Drug Treatment Court Program to be a member of each Child and Family Team when the child is involved in one of these programs.
5. Recommend a staff member from the Family Court be a member of each Child and family team in Family Court Judicial Districts.
6. Encourage Chief District Court Judges to sign, and to participate in the implementation of the local MOA for the Comprehensive Treatment Services Program.
7. Support the concepts and principles of system of care through encouraging and assisting in the training of Judges and other child/family related AOC/judicial staff.
8. Collaborate with other departments in training efforts to address system of care as the methodology for accomplishing CTSP mandates.
9. Collect AOC relevant data, and to the extent permitted by law, provide information to DHHS for the report to the legislature on the program information outcomes listed in Section 21.60(g) as re-written in SB 163 Section 1(a) and Section 1(b).

Department of Health and Human Services

The Department of Health and Human Services, in the service of children and adolescents and their families who are at risk of institutionalization or other out of home placement, agrees to:

1. Participate in the State Collaborative.
2. Require local and regional counterparts of DHHS to implement system of care approach in accomplishing CTSP mandates.
3. Require collaboration for the financing and administration of CTSP by all sections/divisions working with children, adolescents and families.
4. Develop an inventory of resources and services for children, adolescents and families in order to eliminate cost shifting and facilitate cost sharing.
5. Encourage local and regional counterparts of DHHS to participate in the local and regional community collaboratives.
6. Collaborate internally with sections and divisions in training activities to promote system of care as the approach for accomplishing CTSP mandates.
7. Collaborate with other departments in training efforts to address system of care for accomplishing CTSP mandates.
8. Collaborate with DJJDP and other affected state agencies to develop standards for intervention and treatment with special/target populations.

9. Require local counterparts of the divisions of DHHS to sign and implement the provisions of the local MOA as a pre-condition for receiving CTSP funds.
10. Work within its Divisions to develop common language, definitions, assessment measures, outcome tools, and data collection methodology.
11. Work jointly with the Department of Juvenile Justice and Delinquency Prevention, department of Public Instruction and the Administrative Office of the Court to provide structure, information, and guidance to assist local staff in working with local mental health agencies to provide services.
12. Support the Department of Juvenile Justice and Delinquency Prevention, Department of public Instruction and the Administrative Office of the Court in the following efforts:
    - Completing of CTSP eligibility screening of referred youth.
    - Partner to provide appropriate services for youth, including placement.
13. Support the Division of Medical Assistance (DMA) in the following efforts:
    - Research options for financing programmatic efforts with Medicaid funds.
    - Estimate immediate and long term appropriations requirements associated with Medicaid financing.
    - Develop State Medicaid Plan amendments and financing policies after approval of the Secretary and in accordance with federal guidelines.
14. Collect data in order to report to the legislature on the program information outcomes listed in Section 21.60 (g) as re-written in SB 163 Section 1 (a) and Section 1 (b).
15. Collect data in order to report to the legislature on participation in Child and Family Teams of the Department of Public Instruction, Administrative Office of the Courts, Department of Health and Human Services, and Department of Juvenile Justice and Delinquency Prevention.

The Department of Juvenile Justice and Delinquency Prevention agrees to:

1. Participate in the State Collaborative.
2. Participate in local and regional community collaboratives.
3. Participate in and provide collaborative training.
4. Encourage Area Administrators, Chief Court Counselors, and Facility Directors to sign, and to participate in the implementation of the local MOA for the Comprehensive Treatment Services Program.
5. Collaborate with other agencies in developing protocols for the sharing of specific child and family information.
6. Develop a more uniform screening process in determining juveniles that are appropriate for referral to the Comprehensive Treatment Services Program.
7. Collaborate with other departments in training efforts to address system of care as the methodology for accomplishing CTSP mandates.
8. Collaborate with DHHS and other affected state agencies to develop standards for intervention and treatment with special/target populations.
9. Collect DJJDP relevant data to provide information to DHHS for the report to the legislature on the program information outcomes listed in Section 21.60(g) as re-written in SB 163 Section 1(a) and Section 1(b).

Glossary

Best Practices: Treatment approaches and services that are considered to be among the best available from a national perspective.

Braided Funds: Braided funding is the pooling and coordination of resources of all stakeholders involved with a child and family, while maintaining the integrity of each agencies funding stream.

Categorical Funding: Funds that can only be used for certain services and/or populations.

Child and family teams (CFTs): Child and family teams plan and coordinate services and supports to children and adolescents and their families using CTSP and braided funds. Team members are front line agency staff, the family, youth, and other stakeholders directly involved in the treatment, habilitation, and/or support of the child and family. Any participating agency including DSS, DPI, DJJDP, or DMH/DD/SAS may initiate and lead a child and family team. The child and family team works in full partnership with the family to make service decisions and to coordinate delivery of those services.

Collaboration: Collaboration is often preceded, as a system, by coordination and cooperation. Collaboration is characterized by:
☐ Families as full partners in service delivery, who drive services and supports.
☐ Community involvement
☐ Interdependence and shared responsibility among stakeholders

Collaboratives
☐ Local: The local community collaborative is composed of various community agencies, service providers, organizations, families, and advocates who are concerned and committed to children and adolescents with mental health, substance abuse, and developmental disabilities needs and their families. These members work as a team to support and oversee meeting the outcomes identified by children, adolescents and families and determined by consumer satisfaction, their communities' child and family teams and the development of their local system of care.
☐ Regional: The regional collaborative is composed of those regional staff from various state agencies and families who serve the functions of planning, conflict resolution of local issues, technical assistance to local collaboratives, and policy guidance recommendations to the State Collaborative.
☐ State: The State Collaborative is composed of representatives from state level agencies, families, child and family advocates and other systems to provide recommendations to the various Departments about ways to coordinate services, funding, training, and reporting requirements.

Consumers: This is a term that has evolved from patient to client to consumer and refers to the children, adolescents and/or family who are receiving their identified services and supports.

Cost Shifting: When one system decides, without consulting youth, family, or child and family teams, that a youth would be better served in another system other than the one in which the youth is currently served. One system arbitrarily determines that a youth can be better served in another system.

Evidence Based: Evidence Based Treatment (EBT) services are research-validated therapies.

Flexible Funds: Funds identified outside of categorical funding that may be used for non-traditional purchases that allow a youth at risk of out of home placement to remain at home.

Health Choice: The state health care insurance system for families that are ineligible for Medicaid, but do not have the resources to provide private medical insurance coverage. Many of the services funded are the same as those offered through Medicaid.

Medical Necessity (from DMA Child Level of Care Document): "Treatment must be medically necessary: there must be a DSM-IV-TR Axis I current diagnosis reflecting the need for treatment and the service must be necessary to meet specific preventive, diagnostic, therapeutic, rehabilitative, palliative, or case management needs of the child.

Special/Target Populations: These are the youth identified in Session Law 2001-424, Section 21.60, and are those populations that have traditionally been under-served and/or not served appropriately. These include youth who are Deaf/Hard of Hearing, Deaf-blind, with challenging sexual behaviors, co-occurring disorders, serious emotional disturbance, and/or substance abuse treatment needs.

System of Care: Is a model of care that is considered to be a best practice model. An approach to systems serving children and adolescents and families that adheres to System of Care Values and System of Care Principles.

System of Care Principles

☐ Array of appropriate services addressing the whole child/family
☐ Individualized, integrated service plan, developed from a person centered planning process
☐ Services are seamless, clinically appropriate, delivered in least restrictive, most normative environment
☐ Family are full participants in planning and delivery of service
☐ Integration and collaboration between all systems involved in Child/Family's life—Case Management to ensure early identification with positive outcome anticipation
☐ Smooth transition to adult service systems
☐ Rights protected and effective advocacy
☐ Receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

System of Care Values: Child-Centered, Family-Focused, Community-Based, Culturally Competent

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Regarding Comprehensive Treatment Services Program for Children At Risk for
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State Fiscal Year 2005/2006 through 2007/2008

SIGNATURES OF PARTIES TO THIS AGREEMENT:

Dan Stewart for Carmen Hooker Odom 3-22-06
Carmen Hooker Odom, Secretary — Date
Department of Health & Human Services

George L. Sweat 03-07-06
George L. Sweat, Secretary — Date
Department of Juvenile Justice & Delinquency Prevention

3-1-06
Ralph A. Walker, Director — Date
Administrative Office of the Courts

3/19/06
June Atkinson, Superintendent — Date
Department of Public Instruction