

# PRACTICE NOTES

For North Carolina's Child Welfare Workers

From the NC Division of Social Services and the Family and Children's Resource Program

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*In summarizing research, we try to give you new ideas for refining your practice. However, this publication is not intended to replace child welfare training, regular supervision, or peer consultation—only to enhance them.*

## Let us hear from you!

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## BEING A WISE CONSUMER OF SERVICES FOR FAMILIES

We live in a consumer society. Each of us, like it or not, is a consumer. We buy gifts for our loved ones, food to get us through the week, and other services when we need them.

Each purchase, each buying decision is surprisingly complicated, requiring us to assess our needs, shop around to see what is available, and then make a purchase based on price and other information. When we're happy with what we picked out, we feel smart and satisfied. When we're not, we vow to do better next time.

If you work in child welfare, the situation is a bit more complex, because quite often your job calls upon you to be a consumer of services on behalf of vulnerable children and families. In most areas of the service continuum—particularly in-home services and foster care—child welfare professionals must be savvy consumers and “tough customers” with the ability to recognize and get high quality services for children and families.

This can be a tall order. For the most part, you must develop the knowledge and skill needed to do this on the job. You don't have a *Consumer Reports* you can use to guide your decisions.

Even if you can identify precisely what a child or family needs, appropriate services can be difficult to find. Shifting availability of resources as providers come and go and the landscape changes can be a problem in all communities.

At the same time, this is a challenge that must be met. Ensuring children get appropriate and timely services can have a direct connection not only to their well-being, but sometimes to their permanence and safety as well. What you do as a consumer of ser-

vices on behalf of families and children can have serious and far-reaching consequences.

This issue of *Practice Notes* offers information to help you be a good “consumer” in the field of child welfare in North Carolina. Among other things, this issue:

- Explores the concept of evidence-based practice (EBP) and defines many of the categories of evidence-based practices in children's mental health
- Explains how to use the medical home approach to help improve the quality of health and mental health care services received by families and children
- Discusses ways for you to make a long-term difference by empowering the families you serve and teaching them to be savvy consumers on their own. ♦



## A Broad Range of Service Needs

The range of services needed by the families and children involved with the child welfare system is incredibly broad. It is not unusual for child welfare professionals to be responsible for selecting or connecting families with services in many different areas, including:

- Anger management
- Batterer/abuser treatment
- Dental
- Developmental
- Educational
- Medical/physical health
- Mental health therapies
- Parenting classes
- Psychological evaluations
- Sex offender treatment
- Substance abuse treatment

# UNDERSTANDING EVIDENCE-BASED MENTAL HEALTH PRACTICES

Here are a few key points to help you effectively advocate and coordinate services on behalf of families.

## **Understand what an “evidence-based” practice is.**

An approach to prevention or treatment is considered evidence-based when it is shown to be effective through some form of documented scientific evidence. The evidence can include controlled clinical studies, or less rigorous demonstrations of effective outcomes with a specific population. The principle behind evidence-based practice is that clinicians use approaches that have been proven in some way to be effective, rather than relying solely on tradition, personal beliefs, or anecdotal evidence (USDHHS, 2008).

One caveat: an intervention may still be effective for an individual child or family even if it’s not recognized as an EBP. Many factors determine whether a therapist is successful with a particular client, and some of them are hard to measure (NAMI, 2007). For example, the quality of the therapeutic relationship between an individual client and therapist has an important influence on outcomes. In fact, one concern is that an over-reliance on EBPs may prohibit clinicians from exercising their own best judgment as to how to provide the best possible care for an individual. As a result, many organizations work to balance the scientific prescriptions of a program with the practical considerations of relationship and experience (USDHHS, 2008).

Sometimes there are barriers to finding an appropriate EBP. Due to cost and training requirements, some interventions are not available in some communities. In addition, not all EBPs have been studied in culturally and racially diverse communities, so their effectiveness with one population can’t necessarily be generalized to being effective with everyone (NAMI, 2007).

**Educate yourself about providers in your area and the type and quality of service they provide.** Mental health professionals should be able to describe the type of treatment they will use with a child or family, and why the particular treatment was chosen. See the list on this page for questions you might ask to help you and the families you refer understand the interventions that a provider offers.

**Don’t be embarrassed to ask additional questions.** If you don’t understand exactly what a provider is saying, he or she has not explained it clearly enough. Even for child welfare social workers, sometimes it can be intimidating to ask follow-up questions of other professionals. We assume that we must be missing something. If you’re not able to clearly explain to a family, youth, or supervisor what a provider has told you, keep asking questions until you can!

For parents and youth, listening to you engaged in dialogue with a provider can serve as a model for respectfully

## **How Using Evidence-Based Practices Benefits Child Welfare Agencies**

- Helps child welfare workers and supervisors empower families in crisis to resolve their own conflicts, using well-tested programs.
- Enables agencies to refer families to services that have been scientifically researched and proven effective, which in turn may cause the families to make a greater commitment to participation.
- Provides child welfare workers with a better understanding of the range of programs available so they can make informed choices when referring families to services. (Source: CEBC, 2010)

seeking information and clarification, and for making informed decisions about care.

**Involve families and youth.** Exercising choice in treatment is important for everyone. Every family has unique qualities, beliefs, and experiences which may prompt them to rule out or gravitate towards a particular therapy or clinician. Even if there are few treatment options in your community, encourage families to express their views as they select and then participate in treatment. You can coach parents or youth before an appointment to write a list of their own questions, concerns, or observations to discuss with the provider.

Families are more likely to follow through with therapy—and have their needs met—if they are active partners in treatment and are able to be honest with therapists about their concerns. Sometimes they need explicit permission to do so.

## **QUESTIONS TO ASK PROVIDERS**

Child welfare professionals and families may find it helpful to ask the following questions when talking with providers about evidence-based treatment options (NAMI, 2007):

- Why are you recommending this treatment and what are the alternatives?
- What is the goal of the treatment being recommended?
- How will we know if we’re reaching our treatment goals?
- What are the risks and benefits associated with the recommended treatment?
- Is there research or evidence to support use of this treatment?
- Is there research showing that the recommended treatment works for families like ours?
- What training or expertise do you have with the recommended treatment?
- If you are not recommending an evidence or research-supported treatment, why not?

## CURRENT EVIDENCE-BASED PRACTICES IN CHILDREN'S MENTAL HEALTH

The chart below, reprinted from a guide from the National Alliance for Mental Illness (2007), provides a quick reference for evidence-based psychosocial interventions by diagnosis for children and adolescents. It also lists the medications commonly prescribed for children and adolescents with mental illness by diagnosis. Brief descriptions of some of the interventions referred to in the chart can be found on the following page.

Diagnosis	Evidence-Based Psychosocial Interventions		* Psychopharmacology
<b>Anxiety</b>	Ages 9–18	Cognitive Behavioral Therapy (CBT)	**Antidepressant medication (Selective Serotonin Reuptake Inhibitors—SSRIs); Benzodiazepines (no controlled evidence, but used in clinical practice).
	Ages 3–17	Exposure Therapy	
	Ages 3–13	Modeling Therapy	
<b>Attention Deficit Hyperactivity Disorder (ADHD)</b>	Ages 3–12	Behavior Therapy (in home and in school)	Stimulant and non-stimulant (Strattera) medications. (FDA requires a patient medication guide alerting consumers of possible serious side effects.)
	Ages 3–16	Parent Management Training	
	The combination of behavior therapy and medication is often most effective in treating ADHD		
<b>Autism</b>	Ages 3–13	Behavior Therapy	Antipsychotic medication has been shown to reduce aggression
	Ages 3–13	Individual and family therapies that target communication skills, interaction skills, and behavior modification.	
<b>Bipolar Disorder</b>	No controlled studies of psychosocial interventions for youth with bipolar disorder have been done. However, behavior therapy, family education, and support benefit youth and families and improve relationships, communication, and coping skills.		Mood stabilizers (Lithium and Valproate—an anti-convulsant medication); Atypical antipsychotic medication; and other medications may be appropriate.
<b>Conduct Disorder/ Oppositional Defiant Disorder (CD/ODD)</b>	Ages 3–15	Parent Training (multiple EBPs for different age groups)	Antipsychotic medication & mood stabilizers. (CD and ODD often co-occur with other mental illnesses so other medications may be appropriate.)
	Ages 9–15	Anger Coping Therapy (targets skill development in school)	
	Ages 6–17	Brief Strategic Family Therapy (BSFT)	
	Ages 13–16	Functional Family Therapy (FFT)	
	Ages 9–18	Treatment Foster Care (TFC)	
	Ages 12–17	Multisystemic Therapy (MST)	
	Ages 12–17	Mentoring	
	Ages 9–18	CBT	
<b>Depression</b>	Ages 9–18	CBT	**Antidepressant medication (SSRIs)
	Ages 11–18	Relaxation Therapy	
	Ages 12–18	Interpersonal Therapy (IPT)	
	Ages 12–18	Family Education and Support	
	The combination of CBT and medication is often most effective in treating major depression.		
<b>Schizophrenia</b>	No controlled studies of psychosocial interventions for youth with schizophrenia have been done. However behavior therapy, family education, and support benefit youth and families and improve relationships, communication, and coping skills.		Antipsychotic medication

Information in the chart is based on reviews by Burns, Chorpita, Chambless and Halloran, Hoagwood, Jensen, Weisz, and the authors of the NAMI Guide (2007).

\* Generally, there is limited research on children's medication use, but more research exists on the utilization of ADHD medication.

\*\* The Food and Drug Administration (FDA) has issued a "black box" warning about the increased risk of suicidal thoughts and behaviors in youth being treated with antidepressant medications.

## SOME COMMONLY PRESCRIBED EVIDENCE-BASED INTERVENTIONS

From "Choosing the Right Treatment: What Families Need to Know About Evidence-Based Practices" (NAMI, 2007).

### PSYCHOSOCIAL INTERVENTIONS

**Cognitive Behavioral Therapy (CBT).** CBT teaches youth to notice, evaluate, and ultimately change their thinking, which in turn impacts their feelings and behavior. In CBT, youth examine and interrupt automatic negative thoughts that they may have that make them draw negative and inappropriate conclusions about themselves and others. For example, if a youth gets bumped in the hallway, his automatic thought may be that someone did it on purpose. So he pushes back and ends up in a fight. CBT helps youth question and eventually stop automatic negative thoughts, and to improve coping and problem-solving skills. Family involvement in CBT includes parents reinforcing more sensible and positive thoughts and helping the child practice this new way of thinking outside of the clinician's office.

**Exposure Therapy.** Exposure therapy teaches children and adolescents how to manage fears and worries to reduce their distress. The therapist gently, persistently, and gradually exposes the child to the situation that causes the extreme fear, while talking with the child about his or her fear and anxiety and providing therapeutic support. The child is introduced to replacement strategies to reduce anxiety (such as deep breathing, exercise, and talking), with the expectation that the fear will be reduced and ultimately eliminated.

**Interpersonal Therapy (IPT).** Designed for adolescents with depression, IPT examines how relationships and transitions affect a youth's thinking and feeling. IPT focuses on the adolescent and helps them manage major changes in their lives, such as divorce and significant loss. Unfortunately, few providers are trained in IPT, so it may be challenging for families to access IPT treatment for their child.

**Behavior Therapy.** Behavior therapy helps a child or adolescent change negative behaviors and improve behaviors in school, at home, and with peers through a reward and consequence system. Goals are set for the child and small rewards are earned for positive behavior. Children may also lose privileges or be put in time-out for a brief period for failing to meet expectations, although the primary therapeutic focus is on reinforcing positive behavior through valued rewards and earned privileges. Families play an essential role in developing goals for their child and in administering the reward and consequence system.

### INTENSIVE HOME AND COMMUNITY-BASED INTERVENTIONS

**Wrap-around Services.** Wrap-around is a philosophy of care that includes a planning process with the child and family that results in a unique set of community services and natural supports individualized for that child and family to achieve a positive set of outcomes. The family meets with a wrap-around facilitator and together they explore the family's strengths, needs, culture, goals, past successes, and expectations. Families add members to the team and team members take responsibility for action steps to benefit the family. Once outcomes are accomplished and the team nears

### Trauma-Focused CBT

TF-CBT helps children aged 4-18 and their parents overcome the negative effect of traumatic life experiences. Comprised of 12-16 one-hour sessions, it teaches children skills such as emotion and stress management, personal safety, coping with trauma reminders, and linking trauma-related thoughts, feelings, and behaviors. TF-CBT teaches parents to encourage children's use of these skills, and teaches parenting skills. It is associated with sustained improvement in PTSD symptoms, depression, anxiety, behavior problems, and sexualized behaviors, as well as reduced feelings of shame and mistrust. TF-CBT has been found to be highly effective with youth in foster care, reducing trauma symptoms and placement interruptions (i.e., running away, arrests). Parental involvement in TF-CBT increases the positive effects. Thus, involvement of both foster and birth parents in TF-CBT is highly desirable, particularly when reunification is a goal. TF-CBT allows for substantial flexibility to facilitate birth parent participation (FFTA, 2008).

its goals, the transition is negotiated with the team. The family and team decide how the family will continue to get support after they have formally transitioned out of wrap-around. The team also establishes how the family will return to wrap-around, if necessary.

**Multisystemic Therapy (MST).** MST is short-term and intensive home-based therapy. MST therapists have small case loads (from four to six families) designed to meet the immediate needs of families. The MST team is available 24 hours a day, seven days a week. MST therapists work to empower families by identifying family strengths and natural supports. MST therapists work with the family to address barriers such as: high stress, parental substance use, poor relationships within the family, and more. The MST team uses evidence-based therapies in working with youth and their families, including behavior therapy, CBT, and others. Families take the lead in setting treatment goals and MST therapists help them to achieve those goals. Research has shown that MST is an effective alternative to incarceration for youth involved in the juvenile justice system.

**Treatment Foster Care (TFC).** TFC is a placement outside of the family home for youth with serious mental health treatment needs. Trained treatment parents work with youth in the treatment home to provide a structured and therapeutic environment while enabling the youth to live in a family setting. Youths are placed in TFC because of their serious treatment needs and difficult behaviors, to allow them to receive a more intensive level of treatment in the community with ongoing contact with biological families, when feasible. Treatment foster parents work closely with the TFC agency, the child's treatment team, and other professionals, which may include a teacher, therapist, and psychiatrist, to help develop and implement a treatment plan.



## MEETING CHILDREN'S NEEDS WITH THE MEDICAL HOME APPROACH

Child welfare professionals are naturally concerned about the well-being of the children they encounter. Many of these children already have or are at risk for special needs which can negatively affect them in a number of ways. Physical health issues left unidentified and untreated in childhood can have serious implications for functioning in adulthood (Sanchez, Gomez, & Davis, 2010). Unmet mental health needs, too, can lead to serious consequences later in their lives, including homelessness and incarceration (Kerker & Dore, 2006).

Fortunately, by learning about and actively supporting the medical home approach, you can help improve the quality of health and mental health care services that families and children receive while they are involved with child welfare services, and afterwards.

### THE MEDICAL HOME

A medical home is a partnership between the family and the family's primary health care provider. Through this partnership, the medical home provides a single point of entry to a system of care that facilitates access to medical and nonmedical services.

#### HEALTH CONCERNS OF CHILDREN IN FOSTER CARE

- Nearly all (87-95%) of children in care have at least one physical health problem; more than half have more than one.
- Health issues commonly experienced by children in care include growth delays, neurological impairments, vision and hearing deficits, malnutrition, anemia, respiratory problems, chronic ear infections, severe allergies, and failure to thrive.
- Children in care also have high rates of developmental problems including language disorders, social skills deficits, delayed motor skills, learning disabilities, and cognitive impairments.
- Children in care also have high rates of behavioral health issues. It is estimated that 50% to 80% require mental health services, compared to 20% of children not in foster care.
- Children sometimes enter foster care with chronic health issues that have been poorly managed.
- Problems in the provision of health care services to children in foster care include duplication, fragmentation, and gaps in services due to lack of continuity and coordination of care and poor communication among providers.



Sources cited in Sanchez, Gomez, & Davis, 2010

In a medical home, a physician leads a team which delivers and directs care that is comprehensive (sick and preventive/well care), compassionate, coordinated, continuous, culturally effective, accessible and family-centered. A medical home allows primary care providers (i.e., pediatricians or family physicians), parents, child welfare professionals, and other stakeholders to identify and address all of a child's physical and mental health needs promptly and as a team.

### BENEFITS FOR CHILDREN

Medical homes benefit all children by providing a consistent, ongoing relationship with a primary health care provider and team who know the child well. This consistency is particularly helpful for children in foster care. A medical home preserves the relationship children have with their doctors and ensures medical records don't get lost, even when they return home or change placements. Also, because they often have special health care needs requiring the services of many professionals, children in foster care derive special benefit from the coordination of care provided by a medical home. Other benefits provided by medical homes include:

- Doctor visits that aren't rushed
- Easier access to specialists
- Improved quality of care, with fewer errors and preventable complications
- Less parental worry and burden
- Fewer hospitalizations and ER visits
- Less missed school and missed time from work
- More preventive health care

### ENDORSED BY FEDERAL LAW

The medical home approach is embraced by physicians in North Carolina and across the country. Use of the medical home approach with children in foster care is also strongly supported by federal law. Part of the Fostering Connections to Success and Increasing Adoptions Act (HR 6893) directs states to establish a medical home and oversight of prescription medication, including psychotropic drugs, for every child in foster care (Center for Public Policy Priorities, 2008; Children's Defense Fund, 2008). The overall goal of this provision in the law is to ensure continuity of health care for all children in foster care.

### PRACTICE IMPLICATIONS

To work for children and families involved with the child welfare system in North Carolina, the medical home approach needs you. Here's what you can do:

**Make sure the children you work with have a medical home.** If their primary care provider (pediatrician

## MAKE A DIFFERENCE: ENROLL CHILDREN IN CCNC

When they are enrolled in Community Care of North Carolina, North Carolina Medicaid's primary case management program, children are assured of having a medical home. Belonging to CCNC has advantages over just being enrolled in straight Medicaid:

- **Families may have a care manager** who can help them manage the child's health care, show them how to keep the child healthy, and access specialists and other service providers such as Early Intervention.
- **Families can choose a medical home for the child or continue to use the child's existing medical home.** If an enrolled child does not already have a medical home, one will need to be chosen. Many pediatricians and family doctors are already medical home providers with CCNC. Contact the Medicaid program in your agency for a complete list of medical home providers participating in CCNC.
- **Families can call their medical home for advice day or night, seven days a week.** For daytime and after-hours phone numbers, check the child's Medicaid ID card.
- **The child will receive regular sick care and well care** at his or her medical home. Care by specialists to address chronic conditions and special needs will be coordinated by the medical home.

### Children in Foster Care

Under federal regulations, children in foster care are designated as special needs. As such, their enrollment in CCNC is entirely voluntary. Because many families and child welfare professionals are just now learning about the benefits of medical homes, most children in foster care in North Carolina today do not have a medical home through CCNC. As a child welfare professional, you can do something about this.

If you are a foster care (placement) worker, confirm that

or family physician) considers him or herself a medical home, the child has one. If the child does not have a medical home . . .

**Educate Families.** At every stage of child welfare work (Assessment, In-Home, Foster Care, and Adoptions) make a point of talking with birth and resource families about the benefits of medical homes. If they or the child are Medicaid eligible, encourage them to enroll in Community Care of North Carolina (CCNC). For more on this, see the box above.

**For children in foster care who don't already have a medical home:** Work with the Medicaid staff in your agency. Partner with them to enroll the child in CCNC.



every child you work with already has a medical home. If so, try to ensure the child continues to see that provider. If that is not possible, try to keep the child in the same Community Care of NC network so that information from the previous medical home can be shared easily with the new medical home.

If a child in foster care does not have a medical home, partner with the Medicaid staff in your agency to enroll the child in Community Care of NC.

### Changing Medical Providers Is Easy

A common misconception about CCNC is that it can be hard to change providers. Actually, it's easy. When a child or family wishes to change primary care providers, they submit a change request to the Medicaid program within their county DSS. The new primary care provider's number is entered, a new Medicaid card is automatically generated, and *voilà*, the change is made.

### You Can Find CCNC Providers Near You

As the map above illustrates, through its 14 networks, CCNC covers the entire state, so it should be easy to find a CCNC provider in your county. Simply contact the Medicaid program in your agency for a complete list of medical home providers participating in CCNC.

**Know the medical homes in your community.** Contact the Medicaid program in your agency for a complete list of medical home providers participating in CCNC.

**Partner with Medical Homes.** Make it clear to others that you understand the benefits of the medical home approach. Child and Family Team meetings (CFTs) are a great place to do this. The medical home approach is a natural fit with CFTs.

### TO LEARN MORE

Select from the side bar at <[www.medicalhomeinfo.org/tools/](http://www.medicalhomeinfo.org/tools/)>

Special thanks to Betty West and Drs. Marian Earls, Gerri Mattson, and Emma Miller for their contributions to this article.

## PASS IT ON: EMPOWERING FAMILIES AND YOUNG PEOPLE TO BE WISE CONSUMERS OF SERVICES

As child welfare professionals, we are often called upon to broker services on behalf of children and families. Yet brokering services will never be enough to meet their needs in the long run. To truly make a long-term difference, we must pass on what we know and nurture people's abilities to find services that are right for them.

Here are some ways you can teach families and youths to be strong consumers and advocates for themselves:

**Steer away from doing "for" in favor of doing "with."** Include adolescents and parents in decision-making and treatment planning as much as possible.

**One on One Time.** In individual meetings, engage parents in the process of learning about and selecting services. Be sure to share as much information about services as you can and encourage them to ask questions. Coach families in the process of finding a provider who can meet their needs—be a practice partner so that families can become comfortable formulating and asking questions of therapists and other service providers.

**Child and Family Team Meetings.** CFTs are a good place to initiate conversations with youth and their parents about their attitudes and beliefs about mental health and health care. Exploring these topics with families will allow them to bring to the forefront their own perspective about their needs.

CFTs can also be a natural fit for "consumer" skill development. Even though some services may be court-ordered, inviting families to lead with their ideas about the type of services they believe will be helpful validates help-seeking and demonstrates family-centered practice.

CFTs can sometimes be forums in which family members can demonstrate what they know about finding services. For example, in her work with one particular family, a North Carolina child welfare caseworker was apprehensive that a parent was not following through on the case plan, and that as a result one of her children was not receiving the mental health services he needed. Yet at the CFT meeting she was pleased to learn that the child's mother "had explored options for her son on her own and brought support to the table. With her resource and some others, we were able to meet the needs of the family" (Duke Univ., 2009).

**Partner with resource families caring for adolescents in foster care.** When they understand the importance of deliberately instilling health values and beliefs in



**Working with youth and families to develop their help-seeking skills is an important part of child welfare work.**

children, foster and kin caregivers may be able to help teenagers internalize beliefs that will translate into help-seeking behaviors while youth are in care or after they leave the system. Resource families and child welfare professionals can teach foster youth to appropriately identify a health or mental health need and then locate and access appropriate services (Unrau, et al., 2006).

**Focus on support networks.** Reinforce youth and parent support networks, including peer connections, relationships with kin, schools, churches, and other groups. Doing so will promote the stability in natural helping networks, increasing the chances

that families' needs will be met once they are no longer formally involved with the child welfare system.

Valuing the knowledge that families bring and expanding their access to additional information and resources promotes lifelong skills in information-seeking and decision-making as consumers of services.

### RESOURCES

- **Child and Adolescent Psychiatrist Finder.** American Academy of Child and Adolescent Psychiatry. Provides fact sheets to help families and professionals select a child or adolescent psychiatrist. Includes a searchable database for locating psychiatric help. <<http://www.aacap.org>>
- **Maternal and Child Health Library.** Helps service providers and families find available national, State, and local resources that can address child and family needs in areas such as education, health, mental health, family support, parenting, child care, and financial support. <[http://www.mchlibrary.info/KnowledgePaths/kp\\_community.html](http://www.mchlibrary.info/KnowledgePaths/kp_community.html)>
- **NC LINKS,** North Carolina's Foster Care Independence Program, is an ideal way to help youth in care develop their help-seeking capacity. NC LINKS facilitates a youth's transition to adulthood, supporting youth in building skills for independent-living and engaging youth in a support network of peers. A key outcome for all young adults exiting the foster care system is to have access to routine mental health, health and dental health care (NCDSS, 2010).
- **Health Care Skills Checklist.** For use in the context of LINKS and Independent Living. Recommended by Dr. Marian Earls, President, NC Pediatric Society <<http://www.practicenotes.org/Health-Care-Skills-Checklist.pdf>>



## STATE MENTAL HEALTH RESOURCES FOR NORTH CAROLINA

- **NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services.** <<http://www.dhhs.state.nc.us/MHDDASAS/>>
- **Mental Health Facilities Locator.** A searchable directory of mental health treatment facilities and support services. <[mentalhealth.samhsa.gov/databases/facility-search.aspx?state=NC&fullname=North+Carolina](http://mentalhealth.samhsa.gov/databases/facility-search.aspx?state=NC&fullname=North+Carolina)>
- **Mental Health Services Directory.** A list of consumer, family, and advocacy organizations that provides comprehensive information about these mental health resources. <<http://mentalhealth.samhsa.gov/databases/MHDR.aspx?D1=NC&Type=MDR>>
- **Hispanic Youth Violence Prevention Services.** A searchable directory of Hispanic youth violence prevention services. <<http://mentalhealth.samhsa.gov/databases/latino-search.aspx?D1=NC>>
- **State Resource Guide.** A summary of national and State organizations that provide professional advocacy protection, family support programs, financing information, and self-help groups. <[mentalhealth.samhsa.gov/publications/allpubs/stateresourceguides/NorthCarolina01.asp](http://mentalhealth.samhsa.gov/publications/allpubs/stateresourceguides/NorthCarolina01.asp)>
- **State Suicide Prevention Programs.** A list of available State-funded suicide prevention plans and programs. <<http://mentalhealth.samhsa.gov/suicideprevention/stateprograms/NorthCarolina.asp>>
- **Substance Abuse Treatment Facility Locator.** A searchable directory of nationwide drug and alcohol treatment centers. <<http://dasis3.samhsa.gov/>>

### TO LEARN MORE ABOUT EVIDENCE-BASED PRACTICES GO TO...

- **Choosing the Right Treatment: What Families Need to Know About Evidence-Based Practices,** a guide by the National Alliance for Mental Illness (2007). <<http://www.nami.org>>
- **California Evidence-Based Clearinghouse for Child Welfare (CEBC).** Provides child welfare professionals with easy access to vital information about selected child welfare related programs. <<http://www.cebc4cw.org>>
- **North Carolina Evidence Based Practices Center.** Dedicated to the support of evidence based mental health practices, treatments, and interventions. <<http://www.ncebpcenter.org>>
- **CMHS Grantees.** Public and private organizations that receive funding from the Center for Mental Health Services to provide mental health services. <[http://mentalhealth.samhsa.gov/databases/databases\\_exe.asp?D1=NC&Type=CMHS](http://mentalhealth.samhsa.gov/databases/databases_exe.asp?D1=NC&Type=CMHS)>
- **State Statistics.** State-based data on the incidence of mental illness among children and adults, the utilization of inpatient services, and the amount of State spending on mental health. <<http://mentalhealth.samhsa.gov/databases/stats.aspx?D1=NC>>



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