

FACE PAGE

ABSTRACT

Kalamazoo Wraps is a partnership inclusive of families, youth and representatives from all child and family system stakeholders in Kalamazoo Michigan. With Kalamazoo Community Mental Health and Substance Abuse Services as the fiduciary, *Kalamazoo Wraps* will expand and broaden service capacity utilizing culturally competent practices, ensure individualized service plans, and empower children with serious emotional disturbances and their families.

The proposed project, *Kalamazoo Wraps*, intends to build upon the system of care work begun by the county in 1996, and to transform the current model of practice from an intra-system categorical model to *the* means of delivering supports and services throughout Kalamazoo County, braiding responsibility, accountability and authority across systems. System outcomes will include: 1) Evidence-Based Practices Implemented, 2) Cross System Use of Same Screening/Treatment/Support Protocols, 3) Individualized Wraparound Model Implemented Cross Systems for all Children with SED and their Families, 4) Specialized Cultural/Linguistic Practices Implemented, 5) Family/Youth Partnerships Realized Across Systems, 6) Extensive Cross System Training, and 7) A Strong County Wide System of Care Infrastructure in place. Family advocates will serve as co-leaders of the project on all levels (e.g., oversight, work group, administration), and will serve as Care Coordinators in the cross system Wraparound service model. A Family Resource Center will be developed to support families served by all systems.

All children with SED, ages 0-21, will gain from the cross system improvement components of the project. The following four priority populations, who have traditionally been the most challenging to serve towards successful and sustained positive outcomes, are children/youth with SED, who have: 1) multiple contacts and/or placements within the Juvenile Justice system; 2) complex and long standing learning, behavioral and/or neurobiological issues; 3) co-occurring substance use disorder; and/or 4) involvement with the child welfare system, will receive specific interventions. Minimally 100 children and their families annually will receive project services steeped in system of care values. Evidence-based practices will be implemented to support positive, sustained outcomes for the children served, including Positive Behavioral Interventions & Supports, Oregon Parent Management Training, Integrated Co-occurring Treatment for Youth with Substance Abuse and Mental Health Disorders, and Directive Supervision. Relationships with education will be strengthened, resulting in earlier identification of needs and services.

The Evaluation Team, David Hartmann, Ph.D., Rachel Bridges Whaley, Ph.D. and Victoria Curtis, Ph.D., at Western Michigan University Kercher Center for Social Research, is committed to complying with the requirements of the National Evaluation. The team members have extensive training and experience in both quantitative and qualitative research methods and have multiple experiences serving as evaluators for large national evaluation projects related to mental health and children. Kay Hodges, Ph.D., developer of CAFAS will consult to the project.

TABLE OF CONTENTS

BUDGET PAGES

PROJECT NARRATIVE

SECTION A: UNDERSTANDING OF THE PROJECT

Overview: The applicant organization, Kalamazoo Community Mental Health and Substance Abuse Services (KCMHSAS), in full partnership with Kalamazoo’s Multi-Purpose Collaborative Body (interagency workgroup consisting of family/youth leaders, representatives from all child and family serving systems and committed stakeholders), intends to build upon system of care work begun in the county in 1996. The overall goal of the proposed project, *Kalamazoo Wraps*, is to fully implement the five goals of SAMHSA’s Child Mental Health Initiative (e.g., expand community capacity, provide a broad array of effective services, ensure individualized service plans & culturally and linguistically competent practices, promote family /youth empowerment). The project will transform the current model of practice from an intra-system categorical model to *the* means of delivering supports/services throughout Kalamazoo County, braiding responsibility, accountability and authority across systems. System outcomes will include: 1) Evidence-based Practices Implemented; 2) Cross System Use of Same Screening/Treatment/Support Protocols; 3) Strong County Wide System of Care Infrastructure in Place; 4) Individualized Wraparound Model Implemented Cross Systems; 5) Specialized Cultural/Linguistic Practices Implemented; 6) Family/Youth Partnerships/Empowerment Realized Across Systems; and 7) Extensive Cross System Training.

Literature Review: In 1984, the Child and Adolescent Service System Program (CASSP) was initiated in response to inadequate and poorly planned services for children with serious emotional disturbance (SED), with a new ‘system of care’ approach recommended (Stroul & Friedman, 1986). Approximately one-third of children receiving mental health services were found to be receiving services from multiple systems (Burns, et. al., 1995). In the early to mid 1990’s, researchers began examining existing services within systems to better comprehend what works and what doesn’t work in relation to youth and family services (Friedman, et. al., 1996a, 1996b, Quinn & Epstein, 1998, Koyanagi & Gaines, 1993; Knitzer, 1982). There has been increasing evidence that implementing systems of care philosophy produces better outcomes than the application of traditional therapies alone (Stroul, 1993a, 1993b; Burns, et. al., 1995; Rosenblatt, 1998; Burns, B., Hoagwood, K., et. al., 1999). Cultural compliance, family partnerships and individualized care within systems of care have been studied with good results (Nelson & Pearson, 1991), pointing to improved advocacy and cost efficiency (Melaville & Blank, 1991). Services within systems of care are more likely to be accepted and integrated into established community programs when programs focus on culturally and linguistically appropriate intervention strategies (Bentelspacher, et. al., 1994). Cultural competence is intertwined with family participation. Families participate more readily when systems operate in a culturally competent manner, and many minority families report the inclusion of families in services is more effective than children alone (Issacs & Benjamin, 1991). Kalamazoo County found that efforts to serve children with SED and their families required improvements of cross-cultural competence in all aspects of systems of care (Jordan, 1998).

Fragmentation of services between systems, inadequate assessment and intervention techniques and low levels of parental involvement need to be addressed to effectively serve children with SED and their families. There is increasing concerns related to the lack of evidenced-based practices, under diagnosed youth in detention/juvenile justice systems, and the lack of services for “fringe” children who might ordinarily fall through the cracks (New Freedom Report, 2003; Surgeon General, 1999 & 2000; Michigan Mental health Commission Report, 2004). In 2004, a

local planning initiative, which included input from families, advocates and service providers, endorsed a need for service agencies to develop an individualized, wraparound approach to treatment based on culturally competent and evidenced-based practices (Weighman, 2004). An earlier assessment found a local need to identify children with SED not served and/or currently under-served by Community Mental Health as well as in systems most likely to deal with the under-served target population: juvenile justice, child welfare and education (Garfinkel, 1997).

Children within the juvenile justice system exhibit higher than average rates of emotional disturbance (Bilchik, 1997; Rothenberg, 1997; Edens & Otto, 1997). Youth within two systems (mental health & juvenile justice) tend to have poorer treatment outcomes (SAMHSA, 1998). Rothenberg (1997) points out that the common ways of handling juvenile justice cases - informal disposition and probation - provide opportunities for dealing with mental health and substance abuse problems. In fact, many of these youth have co-occurring disorders that require well integrated culturally appropriate interventions. In one state 72% of children on protective service caseloads were “statistically indistinguishable from children in the most intensive mental health treatment programs” (Trupin, et. al., 1993). Within education systems children with SED have a higher incidence of academic failure, more missed school days, lower grades, higher retention and greater dropout rates (Woodruff, et. al., 1998). These children have complex and longstanding learning, behavioral and/or neurobiological issues (e.g., trauma, fetal alcohol, deficits in self-regulation). Kalamazoo’s plan is to emphasize integrating child-serving agency services within the educational settings. This strategy was chosen as most children attend school, schools are a vital link and support to families, and children attend schools who have involvement with other systems, including juvenile justice, child welfare/protective services, and mental health/substance abuse.

Target Population: The target population for the *Kalamazoo Wraps* project will be all children and adolescents, **ages 0-21**, with an emotional, behavioral, or mental disorder diagnosable under *DSM-IV*, and their families, who reside within Kalamazoo County. The targeted child’s level of functioning will be such that the child requires multi-agency intervention, and his/her identified disabilities will have been present for at least one year. It is expected that all children with SED will gain from the cross system improvement components of the project. The following four priority populations, who have traditionally been the most challenging to serve towards successful and sustained positive outcomes, will receive specific interventions as part of the project: children/youth with SED, who have: 1) multiple contacts and/or placements within the Juvenile Justice system; 2) complex and long standing learning, behavioral &/or neurobiological issues; 3) co-occurring substance use disorder; &/or 4) involvement with child welfare system.

Prevalence: National estimates of the population with serious emotional disturbances range from 5% (Stroul & Friedman, 1986) to 10% (U.S. DHHS, 1997). According to the national estimates of the prevalence of SED, the target population in the County could range from 3,086 to 5,555 children. In fiscal year 2003-04, KCMHSAS served 1,115 children with SED and of those only 111 were served through an integrated Wraparound model (Santman, 2005).

Demographics: Statistics from 2000 show that 57,391 of Kalamazoo County’s 238,603 residents were under the age of 18 (**Gender:** 51% males, 49% females). **Racial/Ethnic:** Of those < 18, 79% are White, 14.4% are Black, 4% are Hispanic, 1.6% are Asian and <1% Native American (US Census, 2000). Geographically the County’s population encompasses the Cities of Kalamazoo (32 %) & Portage (19%), four villages (<1% each) and 15 townships (46 %). 12% of

the county residents live at or below poverty, 19.6% of the county residents live at or below 150% of poverty, and 60.6% of the county's poor reside within the City of Kalamazoo. A higher percentage of African-Americans (26.6%) live below poverty than whites (9.4%) (Poverty In Kalamazoo County, 2003). **Income:** The median household income in 1999 for residents of Kalamazoo County was \$42,022. Median household incomes differ substantially depending on whether or not the householder is Black (\$25,871), White (\$43,993) or female householder, no husband present (\$20,260). Similarly, there is a strong correlation between race and poverty status. A disproportionate number and percentage of persons of minority backgrounds are poor, with 29% of African Americans and 22 % of persons of Hispanic origin living at or below poverty, compared to only 9 percent for whites. Overall 12.8% of the children in Kalamazoo County live at or below poverty (U.S. Census, 2000; Poverty in Kalamazoo, 2003). **Disability:** 20,896 persons age 21 to 64 in the County have a disability, with 36.5% within the City of Kalamazoo, excluding persons living in non-independent settings. 16.5% of persons with a disability live at or below poverty (U.S. Census, 2000). **Employment/Literacy:** Only 6% of white males are unemployed at the county level, compared to 13.3% of black males and 6.6% of Hispanic males. Among females, 12.9% of black females are unemployed compared to 9.2% of Hispanic females and only 5.7% of white females. Of persons age 25 and older in Kalamazoo County, 11.2% do not have a high school diploma, with non-completion rates of 6.8% (Asian), 9.8% (White), 21.3% (Non-white), 23.1% (Black), and 31.8% (Hispanic) (U.S. Census, 2000; Poverty in Kalamazoo, 2003). 53% of citizens over the age of 16 in the County function at a high level of literacy (Reder, 1993). **Institutional:** Children are only placed in institutional and foster care settings through the State Department of Human Services, the 9th Circuit Court-Family Division and KCMHSAS. 60 County children, on average, are placed in institutional settings at any point in time, with 224 in foster care, 11 in independent living, 9 in juvenile justice training school institutions (Tripp, 2005; Weighman, 2005; Clomon, 2005). **Referrals:** Annual referrals are anticipated to be coming from predominately elementary, middle and high school settings, as schools are the gathering point for most multi-system children, although most are served in a silo fashion by only one service agency or multiple silos if more than one agency. Possible referrals will include the Kalamazoo specialized Center-based School for children with SED ages 5 to 21 (60), juvenile court school (55), self-contained classrooms in public schools (12), neurobehavioral classrooms (10), and will also come from families, the community, court, mental health, child welfare and education (50). **Language/Immigration:** 4,635 or 1.9% of Kalamazoo County residents were recent immigrants, entering the US since 1990. 6.7% of all County residents speak a language other than English (<1% Spanish, <1% German, <1% Indo Euro, <1% French), with a total of 1.8 % having limited English proficiency (US Census, 2000). **Disparities:** There is an over representation of black males involved in the juvenile justice system as well as in the special education system in the County. Black males comprise 54% of the referrals in juvenile justice and represent 30% of youth in special education, yet only comprise 17% of the population in the county. Over representation of black females in the juvenile justice system is also a concern, making up 43% of the referrals, yet only 16% of the population. African Americans make up 31% of all children served by KCHMSAS, but there are few non-white service providers and there has been no local research into the impact of culture on service provision (Callander, 2005; NCHS, 2004; Weichlein, 2005).

Current Capacity: During 2003-04, the applicant, KCMHSAS, served 1,115 children with SED in Kalamazoo County: 111 received integrated Wraparound services, 134 respite, 179 social skill development services, 294 home-based services, 51 case management services, 499 outpatient

mental health services, 353 crisis services, 54 inpatient care, 13 residential care, and 80 substance abuse services (duplicative count). The numbers in this section do not capture numbers of children receiving private mental health services. In FY2003-04, the 9th Judicial Circuit Court in Kalamazoo received a total of 4,577 referrals. These referrals were based on delinquency, status offences, and abuse/neglect complaints. Through a joint screening project, between KCMHSAS and the Circuit Court, 357 youths were screened for mental health and substance abuse service needs during 2003-04. At the time of the screening 57% of youth with SED were not receiving any type of mental health service. Psychiatric services were provided for 42 youth detained in the juvenile home, Sex Offender Group services were provided for 12 youth and Co-occurring Wraparound Services were provided for 10 youth. The school-based program administered by KCMHSAS and two educational service areas in Kalamazoo screened 1,020 children in 55 schools within the county for unmet and under served mental health service needs. 15% of these children utilized at least one SED service (Pellerito, 2005). Advocacy Services for Kids, the local family advocacy center and local Chapter for the National Federation of Families, provided advocacy, support and/or assistance with referrals for 215 families in 2004. (Houtrow, 2005; Pellerito, 2005; Weichlein, 2005; Wilcox, 2005).

Significance: Kalamazoo's Multi-Purpose Collaborative Body, made up of family advocates and representatives from all child and family serving agencies and local services providers, was established in 1996 to begin to assess County needs related to implementing a system of care for children with SED. Over the years multiple gaps, inadequacies and barriers were identified through countywide focus groups that included a range of constituents and advocates and feedback through surveys and complaint systems. Throughout 2004, child serving agency data was analyzed and additional family and youth focus groups were held in preparation for applying for SAMHSA's CMHI grant. Several significant issues emerged from these planning events:

- 1) Children with SED & their families are underserved (Approximately 1,971 children with SED and their families are estimated to not be receiving any services and significantly more are under served – i.e. there are few wraparound slots, no evidence-based);
- 2) Families do not have a formal or strong voice system wide or on the service delivery level (While the family advocate agency, Advocacy Services for Kids, is well known and respected within mental health agencies, it lacks formal linkages to all of the service systems, and does not have staffing capacity currently to impact the system);
- 3) Juvenile justice cases are on the rise and these youth have high mental health need;
- 4) Minorities are over represented in juvenile justice and special education, and although they have high representation in public mental health services, these services are predominantly provided with minimal attention to cultural issues;
- 5) Services for youth & families are not integrated (despite the number of services, positive outcomes are not achieved frequently enough; a lack of integration of strategies and a common value base is resulting in duplication of services, poor communication between systems, and multiple service plans with contradictory strategies);
- 6) Substance abuse and mental health services for SED youth are often not integrated and there are not specialty services for youth with co-occurring disorders;
- 7) Issues of under-identification are significant, based on SED numbers receiving services;
- 8) Youth do not have a voice (The county lacks a formal sustained mechanism to incorporate youth voice, access, and ownership on system or delivery level).
- 9) Cross system infrastructure is lacking – only existing for the pilot Wraparound project.

The majority of the referrals made for mental health services currently come from the juvenile justice and schools settings in the County. Of those children who are involved with the Intensive Learning Center, a school run by the juvenile justice system for children who are on probation and have been unsuccessful in their home schools, 68% have had past or present involvement with the mental health system and the current services have not been integrated or effective enough for the child's functioning to improve to the extent of a successful discharge from the court services (Houtrow, 2005). Many of the children involved with the courts and screened through the school and court programs were already receiving public or private mental health services that were unknown to the referral source in the court or in the school, or if known, were identified as ineffective. *Kalamazoo Wraps* is intent on developing integrated mental health services in order to transform from a silo model to a community integrated service system that partners with community systems and families to deliver effective and culturally competent care.

Collaborate: The goals of *Kalamazoo Wraps* are consistent with federal, state and local reform efforts (New Freedom, 2003; Michigan Commission, 2004). The project will collaborate with these reform efforts by implementing many of the goals outlined in both reports (e.g., promoting recovery/resiliency, development of integrated system of care that is culturally and linguistically competent, and including family members as full partners). The project will implement these goals in partnership with the Multi-Purpose Collaborative Body, and in collaboration with SAMHSA, the Michigan State Departments of Community Health, of Human Services, of Education and of Labor and Economic Growth. Examples of collaboration include the project's plan to work with the Department of Education to adapt the evidence-based Positive Behavioral Interventions and Supports for special need schools, and working with different State agencies to serve as sites for implementing an evidence-based Parent Training practice.

Michigan currently utilizes monies from the Federal Mental Health Block Grant and the Strong Families/Safe Children initiative through the Department of Human Services to support Wraparound, including the County's small Wraparound program. Kalamazoo receives federal block grant funds for a screening project for youth involved in the juvenile justice system. The proposed project will develop a sustainable model by maximizing resources allocated to the provision of mental health services across systems, including Title XIX of the Social Security Act (Medicaid), Title XXI- S-CHIP, Federal Mental Health Block Grant monies and Public Law 102-321. The project will also collaborate with different state agencies responsible for Federal entitlement programs to specifically link individualized service plans (Circuit Court, mental health, primary care, and social welfare) and educational plans, including IDEA – Parts B and C, and child welfare's Family Preservation and Support Act, TANF and Title IV-B.

SECTION B: IMPLEMENTATION PLAN

INFRASTRUCTURE DEVELOPMENT

Kalamazoo's system of care Multi-Purpose Collaborative Body (MPCB) is comprised of public agency leadership, school superintendents, advocates and community members. The Integrative Action Team (**IAT**), 20 member workgroup of MPCB, includes 4 parents, 2 youths, leaders from 3 schools, child welfare, county human services, KCHMSAS, churches and juvenile justice, with 8 of the members representing different minority groups. **IAT** was established in 2003 to improve services through collaboration. The **IAT** will be the administrative team of *Kalamazoo Wraps* charged with the overall implementation of the project. An Executive Committee and several specialty workgroups will be established. The project will develop structures to assure sustained youth, family, and community voice in partnership at all levels and ensure that the

system of care is responsive to and effective for all ethnic and cultural groups. It will strengthen and sustain the system of care through the creation of a comprehensive governance structure, implementation of evidence-based practices, forge formal relationships cross-systems that operationalize system of care values, create protocols for screening and specialty assessments, develop a family resource center, use evaluation results to inform continuous improvement; and promote transfer of system of care values to practice through specific contractual requirements.

Governance Body: The **IAT** will meet monthly and serve as the Administrative Team responsible for adherence to the MOUs (see Appendix 1), standards of practice and interagency agreements. The Executive Committee, a sub-group of **IAT**, will meet weekly and provide the day to day management of the grant, evaluation oversight and coordination. Both will be chaired by the Principal Investigator and the Co-Principle Investigator/Family. The five workgroups and the Family Advisory Council (which will meet monthly and report to the **IAT**) will include parents, youth, and representative members of cultural, ethnic and linguistic groups, and will be co-chaired by project staff or expert consultants and a family member.

Workgroups: Cultural and Linguistic Competence will assess the existing service system, identify disparities and implement strategies that assure that service providers possess the attitudes, knowledge, and skills to effectively serve **all** children. Sustainability/Fiscal/Transformation will create a formal plan to maximize the use of current resources and funding streams and develop a strategic plan for the transformation of the system of care through the implementation of a community wide training and marketing plan as a means to maintain and grow strategies for achieving sustainability. Care Review will meet weekly to oversee the Wraparound process (setting priorities, gate-keeping, committing resources, monitoring individual service plan development, performance monitoring, hiring staff, barrier busting and training) and coordinate a collaborative *Technical Assistance Team* of professionals and community members trained in Wraparound to provide direct technical assistance to care coordinators and craft resolutions to individual, internal policy or procedural concerns in a manner that enables agencies to prevent and resolve similar problems in the future. Evidence Based/Promising Practice will evaluate the effectiveness of the evidence-based and promising practice interventions and guide modifications needed to ensure positive outcomes for all cultural, racial, ethnic and linguistic groups. Family/Youth Advisory Council will support meaningful participation of parents and youth and have a formal reporting role to the **IAT** and the Board of KCMHSAS. This is a vital link for replication and sustainability in Michigan as KCMHSAS is the Medicaid Prepaid Inpatient Mental Health Plan for the region.

Systems Integration: The governance structure of *Kalamazoo Wraps* will promote systems integration by including representation from state and local child-serving systems on the **IAT** and workgroups. The goal is to create a “seamless” system where families can enter through any door to find care coordination and service delivery that integrates the resources of multiple systems. This commitment entails working within and among the organizations to align policies, procedures and funding practices with system of care values. Partnering with families, cross-disciplinary training to promote best practice, and determined elimination of barriers to effective outcomes will assist in the realization of full systems integration.

Interagency Collaboration has been the driving force of the successful Wraparound project for 10 years and the priority of the **IAT**. There are MOUs between child-serving systems as well as a community MOU for the project (Appendix 1). *Kalamazoo Wraps* will enable more thorough

and potent interagency collaboration via the governance structure and in service delivery, training and evaluation. The IAT will develop systemic policies and practices needed to respond to children and families in a holistic manner, recognize that their well-being is the responsibility of the whole community and not one organization alone. A Wraparound process will involve staff from all systems and natural supports in crafting individualized service plans (ISPs).

Services Integration: An integrated ISP will be prepared for/with each child and family. The plan will reflect family goals, identify needs, resources and cultural preferences. The care coordinator will facilitate communication among providers. The TA Team will support a high degree of service integration through creative problem solving and proactive redesign.

Wraparound Processes: Kalamazoo's current Wraparound process is parent driven, strengths based, needs-driven, culturally responsive, individualized, family centered and it includes natural and informal supports. This program is supervised by an interagency community resource team and financed through multiple funding streams and many in-kind resources from all systems. There is consistently high family satisfaction (90-95%) and a high percentage of children able to stay in their family home/community (80-90%) and continue to live at home or in the community 6 months and 1 year after graduation (83% and 80%), (Houtrow, 2005). Currently, Wraparound draws on the resources of multiple systems but is primarily a mental health-driven effort. Through *Kalamazoo Wraps* the Wraparound model will become "the way of doing business" throughout all systems, agencies, providers and the community. Accomplishing this will involve multiple strategies (e.g., training, implementation of evidence-based/promising practices, partnering with parents, nurturing cultural competency, training parents as care coordinators, countywide system of care values training, and use of Directive Supervision). It is not uncommon in the current system for ISP the individual service planning team to include only the parent and a single provider even when multiple systems/services are engaged with the family. *Kalamazoo Wraps* will provide the infrastructure to develop 'real' Wraparound system wide.

Flexible Funding: All Care Coordinators will have access (through the Care Review Team Workgroup) to these funds as part of the ISP after all other resources have been explored and exhausted. Among other things, flexible funding provides a means to support the creative, normalized, non-traditional (from the systems/agency perspective) and informal interventions (addressing needs and utilizing strengths) identified by the child and family teams.

Care Review: *Kalamazoo Wraps* will establish a collaborative community resource team to oversee the wraparound process including eligibility, referral, enrollment and implementation. Tasks will include targeting and setting priorities, gate-keeping, committing resources, monitoring individual service plan development, performance monitoring, hiring staff, barrier busting and training. This group will provide vital information and feedback to the IAT as it relates to the long term strategic planning for the sustainability of the system of care.

Access: The project will greatly improve the ease of access to effective interventions and supports through screenings, specialty assessments, treatment protocols and availability of desirable evidence-based and promising practices. Clear, specific and comprehensive eligibility criteria will be disseminated to all of the child-serving systems, agencies, schools and the Family Resource Center/ASK. The Care Review workgroup's focus will be on creating simplified, responsive and user-friendly procedures. Service providers' focus will be to provide services that are convenient, comfortable and accessible to all. Considerations will be made in reference to the time, location, frequency and duration of the families' team meetings and other services.

Financing: Local cash funds from KCMHSAS, the Regional Coordinating Agency/Public Act 2, and Education will be used to initiate the project. Over time, funding will be drawn in from multiple streams including: Michigan's Integrated Behavior and Learning Support Initiative grant; Public Act 2; Title XIX of the Social Security Act (Medicaid), Title XXI- State Children's Health Improvement Program, Michigan's Community Mental Health Services Block Grant, State and local mental health funds, County Child Care funds, federal entitlements, including: IDEA (Parts B and H), Family Preservation and Support Act; Title IV-A - TANF, Title IV-B - Child Welfare/Family Preservation and Support Services, Title IV-E - Foster Care, Adoption and Independent Living. Through individualized service planning, all available supports and services will be braided together to create a single care plan for each child and their family.

Workforce Development: The project will utilize multiple workforce development approaches to accomplish its objectives. At the core of these strategies is the value of engaging parents and service providers in a process of continuous quality improvement. The Cultural and Linguistic Consultant will guide ongoing training and education in this area. The project will partner with families at all levels, and providing mentoring and training to build their capacity and comfort to work within the system of care. Collaborative trainings will be held regularly throughout the duration of the project (and beyond) for all child-serving systems and community partners on or about system of care values, Wraparound, assessment, screening, treatment protocols, cultural and linguistic competency, evidence-based and promising practice interventions. The use of the Directive Supervision model will be mandated for public mental health providers (and available to all human services providers) as a method of translating principles and values into practice. Comprehensive and collaborative training opportunities will provide the community with a solid foundation with which to continually build upon, improve and sustain the system of care.

Community Leader Support: The MPCB has endorsed the project as being consistent with the overall goals for system reform in Kalamazoo County. A community MOU has been signed by all of the MPCB members, as well as additional community partners (Appendix 1). KCMHSAS and representatives from the Eastern Service Area, which includes 5 school districts, have made financial commitments. All of the above will be represented on the **IAT**, project workgroups and the Family Advisory Council. In addition to their commitment to shared governance, these members have made important commitments which include: 1) To strive to engage parents, youth and families in the development of a community system of care that is user-friendly, simplified and responsive; 2) To work within and among their organizations to align policies, procedures and funding practices with system of care values; 3) Participate in common training to promote the best principles of Wraparound, while identifying and eliminating barriers to keeping families together; 4) To contribute funding, in-kind resources, and/or staff time; 5) To participate in evaluation and work creatively for improvement of the community system of care.

Replication Plan: The State of Michigan has committed to partner with *Kalamazoo Wraps*. KCMHSAS, as the pre-paid Mental Health Plan for the 4 county region of Southwest Michigan, has multiple linkages to the State and across counties. Many of the proposed services are Medicaid eligible under the state plan. Additionally, KCMHSAS is a member of the State Steering Committee for Evidence Based Practice and is partnering with the Department of Community Health to bring Parent Management Training to Michigan. An emerging finance strategy is the State's attempt to make additional Federal Mental Health Block grant funding available for this project; KCMHSAS received a State interdepartmental agreement (Appendix

1) that the proposed System of Care will be included in Michigan's Community Mental Health Services Block Grant Plan for FY06 and in the state Mental Health Plan for Children and Adolescents with Serious Emotional Disturbances, submitted under Public Law (PL) 102-321. KCMHSAS also has a contractual relationship with The Southwest Michigan Children's Trauma Assessment Center which is part of SAMHSA's National Child Traumatic Stress Network. The Trauma Center, KCMHSAS, and Public Education collaborate to implement models of care that maximize the learning potential and improve social functioning for traumatized children.

Replication through mentoring and train-the-trainers is part of the PBIS model. State national PBIS TA providers will support replication efforts. *Kalamazoo Wraps* will partner with Kalamazoo Regional Education Services Agency and local districts to accelerate implementation of PBIS to make this model available in all high risk schools in the County, expanding beyond elementary settings. Successful collaborative implementation of this model will help the community obtain Federal grants such as Safe Schools/Healthy Students and Infrastructure.

Clinical Network will be strengthened through the implementation of unified protocols for screenings, specialty assessments, through strategic use of evidenced-based and promising practice interventions, and through joint training to unify and improve care planning and cultural competency. Delivery of other existing clinical services (e.g. intensive case management, home based crisis) will continue and benefit from overall infrastructure changes and system of care values. The project's vision is to strengthen the effectiveness of the clinical network through comprehensive, consistent and collaborative service delivery and to integrate three new evidence-based interventions: PBIS, Oregon Parent Management Training, Integrated Co-Occurring Treatment for Youth with Substance Abuse and Mental Health Disorders; and four new and/or expanded promising practices: Wraparound, Directive Supervision, Developmental Pediatrics; and School Linked Psychiatry. Developmental Pediatrics will link pediatric and behavioral services and to expand availability of skilled medication monitoring services. School Linked Psychiatry is an emerging model of service delivery that allows the psychiatrist to have the ability to directly and simultaneously work with the child, parents, primary clinician and school staff to better evaluate the effectiveness and side effects of medication.

Administrative Team: The IAT will meet monthly to oversee the project and have authority to make policy decisions. The Executive Committee of the IAT, which will consist of the Principal Investigator, Co-Principal Investigator/Family, the Co-Project Directors (administrative and family), evaluator and youth advocates, will serve as the Administrative Team and will meet weekly (and/or as needed) to assure the cooperative agreement funds are expended appropriately and ensure all goals and objectives of the project are implemented according to the outlined timelines. The Executive Committee will serve as the day to day management group and will be charged with appointing specialty focus groups to develop, implement and/or monitor specific objectives of the project. This group will be responsible for developing, implementing, and managing the system of care within this project. The Executive Committee will: develop a strategic plan that includes social marketing, local-level evaluation, and sustainability; coordinate services delivered through collaborating child-serving agencies; budget, manage, and expend service funds for required services; integrate funding streams; award and manage contracts for service delivery, training, technical assistance, evaluation, and social marketing; use findings from the National & local evaluation and MIS data to shape future program direction, identify effective/ineffective practices and policies and incorporate into a quality improvement plan; implement care review procedures; monitor the quality and implementation of individualized

service plans; examine the extent to which service decisions for children utilize the least restrictive, most normative, and safest environments that also are clinically appropriate, focusing especially on decreasing the need for out-of-home placements and out-of-community placements; monitor the degree to which care management and other services enhance the strengths, resilience, protective factors, and well-being of children and families.

Training Capacity: Cross systems and community wide trainings will be vital to the success of this project. The goal is to provide training to over 1,000 community members annually, ranging from informational to complex in order to improve, expand and enhance the system of care, reduce stigma and increase the knowledge and skills of all people who interact with children affected by SED. Topics will address all of the identified goals and objectives of the project. Several National, state and local experts will provide consultation for the training, implementation and evaluation of the interventions. Family members will co-train with professionals from all systems. The Directive Supervision, an integral part of the project's training/fidelity plan, will be implemented throughout the mental health system and made available to all providers. It is a comprehensive method of values based supervision that focuses on three main areas: 1) overt and close ties between Human Resource functions and the initiative's values base; 2) data driven decision making at the supervisor's level; and 3) a strength based, behaviorally focused coaching model. The project's focus on comprehensive, consistent and collaborative trainings will impact the community in several positive ways: 1) Service providers will attain the knowledge, skills and tools necessary to complete the appropriate screenings and assessments; 2) these tools will lead to informed recommendations and implementations of clinical interventions; 3) with the addition of several evidence-based and promising practices, service providers will have more effective treatment options available.

Performance Standards: Quality and effectiveness will be monitored, in part, through the local, state, and national evaluation, using CAFAS to determine the extent of recovery that enrolled children demonstrate via the measure of functional behavior across 8 life domains. Surveys will assess satisfaction with services. The Cultural and Linguistic Competency Workgroup will determine how best to regularly measure the extent of cultural competency, family inclusion, and youth participation. Model fidelity in the implementation of evidence-based and promising practices will be assessed by consultants/experts and planned periodic reviews of actual practice. Evaluation results will be used throughout the project to inform strategic planning. The **IAT** will provide oversight to the evaluation, feedback, and revision process. Long term sustainability will be enhanced by processes that embrace continuous improvement to achieve desirable outcomes.

MIS: KCMHSAS has a fully staffed MIS department and is currently able to provide for the electronic collection, storage, management of information within the system of care and is HIPPA compliant. The current MIS system records the type, amount and cost of services covered by Medicaid, cooperative agreement funds, and other local, State, and federal funding streams. Services identified as part of the individualized service plan are entered into the system through an authorization and enrollment process. The MIS system is able to interface with the State CAFAS project and will be able to interface with the National Evaluation through Western Michigan University. The current MIS system is not able to integrate across the collaborating child-serving agencies or function as a tool for coordination of service delivery between agencies. KCMHSAS is actively pursuing a new Windows based MIS system that will permit provider agencies to securely coordinate service delivery that is connected to the public mental health system. The MIS Director, will coordinate the setting up of the new computers, upgrades

and system interface between all of the offices initially and a sub-workgroup (comprised of representatives from all agencies) will guide the development of a fully integrated MIS system.

Office in Community: KCMHSAS is currently located inside the city limits on the bus line within a complex which houses several other child-serving agencies. It is exploring the possibility of co-locating with Advocacy for Kids (ASK) to strengthen partnerships and provide greater accessibility for families. Assessments and intakes are done in a variety of settings, which include: KCMHSAS, schools, family homes, community agencies. The 9th Circuit Court houses Wraparound staff which has led to beneficial collaboration. Parent Care Coordination/ Wraparound services will be housed at ASK. All locations will be physically accessible, welcoming, and culturally attuned (e.g., culturally diverse artwork, some have bilingual materials and signs). While there have been efforts to make families feel welcome in these locations, all of these sites could benefit from improvements. As the goal is to disseminate Wraparound throughout the community, the project will contractually require community-based provision of services wherever the provider network has authority to do so unless the family chooses otherwise or there is a clinical/safety issue that can not otherwise be met. Currently, KCMHSAS services are provided in community locations of the family's choosing (i.e. home/school).

Collaboration: The IAT, Executive Committee and Workgroups will lead collaborative efforts. A community MOU for *Kalamazoo Wraps* specifies the commitment of Mental Health, Juvenile Justice, family members, youth, Social Welfare/DHS and Education to the development of a system of care. Several child-serving agencies have signed inter-agency MOUs. To link this project to the Michigan's system reform efforts, an Interdepartmental agreement was signed by the Michigan Departments of Community Health, Education, Human Services, and Labor and Economic Growth. MOUs will be used to leverage change within the system of care, to engage families as full partners, recognize and work with culturally relevant family beliefs, and to replicate throughout Michigan. Collaboration at the individual child and family team level is vital. Public mental health providers are required via contracts to coordinate services with the primary care system. Wraparound is now used for students with neurobiological concerns to coordinate care among therapists, teachers, aides, psychiatrists, crisis workers, school administrators, and consultants. These students would be eligible for the project through which a more comprehensive and evidence based approach would augment this promising collaboration.

Training/Technical Assistance: Cross system training will be a cornerstone of the project. Professionals serving children with SED will be provided training to develop local expertise in evidence-based and promising practices. The project anticipates training the staff of 20 schools in PBIS, 25 clinicians in Parent Management Training (Oregon Model), 5 clinicians in the provision of Integrated Co-occurring Treatment Model, 5 Care Coordinators in Wraparound (e.g., individualized service planning, facilitation & care coordination) and 20 supervisors annually in Directive Supervision. All providers of services to children within the system of care will be required to participate in trainings (e.g., cultural competency, evidence-based and promising practices as they apply, specialized assessments, screenings including substance abuse, assessment and treatment protocols). Training will be made available to all service providers and interested community members. The new Technical Assistant Coordinator will coordinate all TA needs of the project, interface with the national experts and SAMHSA, and participate on all workgroups and committees. Kalamazoo intends to take full advantage of SAMHSA technical assistance and training opportunities and utilize and develop local expertise.

Social Marketing: The IAT, Executive Committee, all of the specialty workgroups and the Family Support Advisory Council will include social marketing goals in their strategic plans. Disseminating information, providing resources and training will be powerful tools in transforming skills, and reducing the stigma of mental illness. The Social Marketing Coordinator will consult with all workgroups and the Cultural and Linguistic Competency Consultant in the development of diverse tools and of several marketing modalities (e.g., the use of television, newspapers, magazines, billboards, newsletters, radio ads, buses etc.). The Family Resource Center will become a hub of social marketing planning, with input of parents, youth and advocates. The project will have a special focus on developing social marketing plans with school districts, individual schools and individual Parent Teacher Associations. Kalamazoo currently utilizes materials from the Caring for Every Child's Mental Health campaign, which will continue and be expanded along with similar State and local efforts.

Increase Capacity/Quality: The project's ambitious vision is that *all* children with mental health needs will be served through a system of care that derives from shared values. The values will be put into action through blended and braided funding, through the transformation of practice, cross-systems policies and procedures requiring service intervention, all secured through contractual language, new strategies for supervision and committed governance. During the grant project, approximately 100 children annually will be served in the newly developed system of care interventions. Key components of Integrated Co-Occurring Treatment for Youth with Substance Abuse and Mental Health Disorders are: system of care service philosophy, Home-Based service delivery model, integrated services, Motivational Interviewing and resilience focus (Kanary and Shepler, 2005). Annually, 20 children will be served in this model. Through the project, key services, such as care management; intensive home based services, Wraparound, and outreach, will expand by 80 children (These services are reimbursable under the State Medicaid Plan.) In year 2, 20 families will be served annually through Parent Management Training. All enrolled children will be eligible for crisis intervention services, provided through their home based team, their Wraparound Family Team members, or through the local Mobile Crisis Response Team. Each enrolled family will create a safety/crisis plan.

The project will strengthen and expand the use of Evidence Based Practices, linking currently isolated efforts to a larger systems implementation and dissemination plan that will include sustainability and model fidelity in the planning. The project will bring new promising practices into the system of care such as Sensory Integration Therapy, Directive Supervision and use of Developmental Pediatrics and other specialty assessments. As stakeholders come together under shared goals and values there will be a greater volume of effective services in a coordinated manner, with improved access to care and shorter lengths of stay in restrictive services. Funding will be directed away from services with poor outcomes, Federal Medicaid and Mental Health Block Grant funding will be maximized and additional funding sources will be pursued.

Plan Participation: State and local service system leaders, community members, families and youth participated in the planning for and/or development of this application, including all of MPCB, IAT and the Care Review Team for Wraparound. There was substantial involvement from the Michigan Steering Committee for Evidence Based Practice, the State Office of Children's Mental Health Services and Department of Community Health. KCMHSAS began involving parents and advocacy organizations in 1996 in the planning and implementation of community change. The local family advocacy organization, ASK, has been a full partner in the development of this application, with over 34 different family members involved, including

several bi-lingual and those from different ethnic groups. Parents routinely provide input to KCMHSAS, Kalamazoo Public Schools, Kalamazoo County DHS, Circuit Court, and Family & Children Services, and representatives from small community service agencies serving children and families, through a monthly children's mental health services provider meeting, hosted by ASK, and these meetings have been used for the past several months to help shape the application. A focus group of youth were also interviewed at ASK about their needs, priorities and potential "systems" solutions that would improve their lives. **IAT** has 8 members (40%) representing minorities and is working to expand the input of those from all cultures and ethnic groups. The Cultural and Linguistic Competency Consultant will guide the development of strategies to ensure more diverse participation in planning, governance, and leadership.

Nonfederal Match: While the letter of assurance from the Governor brings the full force of the State of Michigan in support of *Kalamazoo Wraps*, it is the following agencies who guarantee match and therein demonstrate interagency cooperation and collaboration: KCMHSAS, \$250,000; Eastern Service Agency of the Kalamazoo Regional Educational Services Agency, \$20,000; and The Public Act 2 Committee housed under the auspices of the Regional Coordinating Agency for Substance Abuse Services, \$30,000 (Appendix 5). The project will use other in-kind donations from Circuit Court (office space for Wraparound Coordinators), Kercher Center for Social Research will provide printing, administrative support, training to parents on evaluation, and Sharon Roepke in-kind consultation (Gay and Lesbian Resource Center). Every child serving agency will donate all levels of staff time to participate in different workgroups and coordination activities, as well as provide meeting and training space. Office space/furniture, utilities, phone, computer, ongoing technical assistance and training, supervision of the PBIS coach are examples of in-kind offerings from Kalamazoo Regional Educational Service Agency.

SERVICE DELIVERY:

Eligibility//Referral/Enrollment: Eligible children will be 0 to 21 years with SED, residing in Kalamazoo County who are enrolled in multiple child-serving systems with a moderate functional impairment and the presence of a condition expected to last a year or more. Priority populations will include children with SED who have: 1) multiple contacts and/or placements within the Juvenile Justice system; 2) complex and long standing learning, behavioral and/or neurobiological issues; 3) co-occurring substance use disorder; and/or 4) involvement with the child welfare system. It is anticipated that broader populations will benefit as the community moves towards incorporating system of care values. Referrals for the project can come from anyone (e.g., any child-serving system, parents, etc.) provided that Kalamazoo County has financial responsibility. The majority of the referrals will likely come from education settings due to the project's focus on schools, the strong collaborative history between schools and mental health and the presence of school based consultants. KCMHSAS Access and Intake will serve as the facilitator for referrals, reviewing referrals to establish eligibility and authorize Wraparound care coordination services based on capacity. KCMHSAS is required to provide services to all who meet SED criteria, if the child does not meet project criteria then alternative services are recommended and the Care Review team works with the family to interface with the recommended services. The Care Review workgroup will monitor the overall care process.

Required Services/Supports: Kalamazoo County's system of care provides **all** of the required mental health services outlined in the cooperative agreement (e.g., emergency, in-home, respite). The system of care provides Individualized Person Centered Plans (same as federal ISP), thus supporting families through a broad array of services and supports. The focus in this project will

be the development of evidence-based/best practice interventions and the creation of an integrated service model, guided by system of care values, which will enable Kalamazoo to move toward “one family, one plan”. In addition to the services already in place, Kalamazoo has begun developing Parent Management Training (Oregon Social Learning Center, 2004), but availability is limited to only 5 families. We have initiated discussions for implementation of PBIS (Lewis et. al, 1998) Directive Supervision (Miles, 2005) and Integrated Co-occurring Treatment for Youth with Substance Abuse and Mental Health Disorders (Kanary and Shepler, 2005) so that we can rapidly implement these strategies once awarded.

Optional Services: Many optional services will be project core components and have been described throughout Section B. Examples include specialty assessments and eligibility screening tools, training in system of care values and evidence-based interventions, cross training for service providers/families, therapeutic recreational activities, school linked psychiatry and occupational therapy, developmental pediatrics, sensory integration treatment. Families and youth direct the choice of what services and supports are necessary and appropriate.

Non-Mental Health: The Individualized Person-Centered Planning (PCP) process includes all aspects of the child’s and as such will include non-mental health services and resources as part of an integrated plan. Funds from this project will not be used to finance non-mental health services. Funding for these types of non-mental health services will be sought through coordination, memoranda of understanding, and agreements with relevant agencies and providers. Representatives from education, medical and health services, literacy services, vocational counseling and rehabilitation and transition services offered under IDEA, protection and advocacy, substance abuse and substance abuse prevention will serve as members of the IAT and workgroups (Appendix 1). All children enrolled into the program will be screened for substance abuse per current practice using the Massachusetts Youth Screening Instrument. Youth needing substance abuse or co-occurring treatment will be referred to specialty services such as the new best practice Integrated Co-Occurring program. Substance abuse prevention services are provided through Michigan’s Regional Coordinating Agency for Substance Abuse, KCMHSAS is the fiduciary agent for this program. Contractual providers are required to coordinate with primary care physicians and assessments include health information. Coordination of services for children with SED and chronic illness is monitored through KCMHSAS Quality Management Unit and Michigan Department of Community Health audits. Literacy interventions for children with SED occur through special education and 504 plans.

Clinical Interventions: Kalamazoo County is committed to continuous improvement of the diagnostic, treatment planning and intervention strategies necessary to assist families in reaching their goals as evidenced by the Community Center of Excellence (COE) plan (Weighman 2004). The COE promises a standard assessment /screening that is uniform, leads to appropriate ancillary services and is person/family centered. COE has developed an assessment and treatment protocol which includes research based objective measures that community agency professionals will use to determine diagnostic and treatment planning needs. Matching children to services will occur initially based on family request and clinical rationale as measured by the “request for service” and appropriate screening measures. All screening/assessment measures and services will be reviewed through the lens of culture and the needs of each individual child and family. Through better communication and collaboration between education, juvenile justice, child welfare, mental health and parents/guardians many more children will be identified earlier and served more effectively. Earlier screenings, use of PBIS, specialty assessments

(developmental pediatrics, sensory integration, psychiatric, psychological, and neuropsychological) and new evidence-based interventions will assist in reaching children sooner and having more positive results. Treatment planning is strength-based, family driven, and culturally sound. Effectiveness will be measured through quality monitoring, use of CAFAS, wraparound fidelity measurement (Directive Supervision) and the National Evaluation.

Assessments that are sensitive to gender and cultural differences: The project intends to ensure that the accuracy of assessments and effectiveness of interventions are not compromised by culture and gender bias. Staff development and supervision will ensure that cultural, in its many forms, is respected and incorporated into planning and service delivery. Consumer satisfaction will provide essential feedback and careful individualized planning facilitation and review will be used to eliminate bias and respond to child and family choice and preference through creative use of a wide range of services, informal support and providers. Clinical Training in Evidence-Based Practices: The project will provide cross training opportunities for providers, families and community members and training in evidenced-based and best practice models and will support the expectation that excellence in service delivery is a right. Currently all child serving mental health providers are required to participate in 24 hours of annual training for compliance with the Children's Diagnostic Treatment Center Administrative Rules. Through this grant, training will focus on implementation of PBIS, Parent Management Training, Integrated Co-Occurring Treatment, Sensory Integration, Wraparound, and Directive Supervision. Training will also focus on the screening, assessment and treatment protocols that will be implemented countywide. The project will collaborate with partners in trauma assessment/treatment to be sure interventions address underlying trauma. Training is expected to result in improved fidelity, a more skilled workforce (evidence based, cultural relevance, family inclusion) and better outcomes for youth. Evidence-Based Practices: The project will integrate the specific evidence based practices into ISPs as deemed appropriate by the care planning team. Other evidence-based/best practices (e.g., PBIS and Directive Supervision) will improve the infrastructure as a whole. Families will learn of evidence based treatment options through marketing, advocacy, and information provided by the care coordinator. Care planning will ensure that all the services and supports work in concert with one another. The project will expand capacity in Parent Management Training from 5 to 25 families. This model trains parents to manage their child's behavioral problems in the home and at school by applying social learning techniques to parent-child interactions for measurable and durable results (Long et. al, 1994). The project will accelerate the adoption of PBIS in school settings and Integrated Co-occurring Treatment throughout. Modifications will be explored so that interventions are adapted to meet needs of different ages, genders, ethnic/cultural groups.

Care management services: Individualized Care: Individualized Person-Centered Plans (PCP) will be developed for every child enrolled, using wraparound principles (e.g. strengths based, family & child guided, culturally relevant, needs driven, etc.). Integrity will be enhanced through Directed Supervision. All families will have direct and immediate access to community support and planning services through ASK and it's ancillary work teams. Wraparound training/supervision The project will hire a full time trainer to provide/coordinate training in all areas mentioned in this application including specialty clinical assessments, treatment protocols, the wraparound process, and cultural competence. Training will be available for mental health providers, staff in all other child serving systems, community organizations and families.

Individualized Service Plans (ISPs): All children and families enrolled will develop their PCPs using a wraparound process. Families will identify who they want involved, where the process is to take place and how the process is to take place (e.g. who they would like to facilitate, record and how often they would like to review their plan). The entire process will be strength-based; from the initial referral, to the development of the plan, to the implementation and throughout the revisions, the child and family strengths, both as individuals and as a whole, will be discovered, discussed and celebrated. Child and family strengths are the foundation of PCPs, the building blocks of every intervention, and the thread that ties the entire process together. Needs will be described in the family's terms and specific strategies/methodologies will be spelled out to accomplish each objective. Plans will include non-mental health needs and make provisions to address those needs. The plan will also clearly designate the lead agency responsible for care management and specify who is responsible for other aspects of the plan. Implementation of the key components is based on a holistic and culturally appropriate understanding of the child and his/her family. Understanding extends from the utilization of sound screening/assessment measures and the implementation of evidenced-based practices.

Coordination with IDEA: All PCPs will act in coordination with services under parts B and H of the Individuals with Disabilities Education Act (IDEA) and will be consistent and coordinate with the child's Individualized Education Plan (IEP). Kalamazoo leaders in Education will participate in governance workgroups, including the Care Review workgroup, to assist in systematic coordination. At the family level, care coordinators will seek to coordinate PSPs and IEPs. In classrooms for youth with neurobiological deficits, supports will be merged by creating a wraparound team focus for the classroom. Kalamazoo has clinical mental health specialists in schools for children being served across systems. The project will expand on this existing process by offering coordinated assessment efforts and shared planning.

Coordination with Social Services: All PCPs will act in coordination with services available through the U.S. Department of Health and Human Services, Administration for Children and Families' Family Preservation and Support Program (Title IV-B, Subpart 2, Social Security Act). Compliance of these mandates will be monitored by care coordinators, supervisors and child welfare representative(s) on the governance body and care review workgroup. Children in foster care with SED are eligible for services. The project will work closely with DHS (child welfare) to provide services to eligible youth in foster/kinship care. The DHS Director has endorsed this project (MOUs appendix I) and DHS staff are on the governance committees.

Quality Assurance: First and foremost the family may choose to revise and or update their plan at any time. On the system level a new, county-wide Care Review workgroup will be established, consisting of the Co-Project Directors, child serving systems representatives selected for their grasp of the values, youth, parents, advocates and members of the Cultural and Linguistic Competence workgroup. The care review group will develop standardized intake and care review instruments that are comprehensive, individualized, culturally sensitive and flexible. The Care Review workgroup will have a broad oversight including on-site reviews of all programs and service offerings (including all of the new evidence-based services and promising practices). The group will monitor PCP development and adherence to wraparound fidelity and conduct an annual satisfaction survey of children and families. This survey process will be tied to Directive Supervision and the evaluation process and will provide the county with important feedback to guide the annual and long-term strategic planning to improve and sustain the system of care.

Grievance Procedure: During the intake process, when plans are revised and annually, each family is informed verbally and in writing about how to file a grievance and appeal if they are not in agreement with their plan. If the addition or withdrawal of any service is disputed the family may bring their concerns to the attention of their care manager, their team, the **IAT** and/or pursue a formal grievance and appeal process through Member Services of KCMHSAS.

Family-Driven care: **Family Partnerships:** Family members and family organizations were actively involved in the conceptualizing the project. All of Kalamazoo County's efforts since 1996 to improve services for children with SED and their families have sought input from parents and youth. Four positions of the 20 members of **IAT** are reserved for parents of children with SED and two positions are reserved for youth. A family advocate and member of the faith community, attuned to the needs of the target population, will be members so that families and community representatives will form 50% of the Administrative Team (**IAT**). (See Appendix 6). Parents will serve as Parent Care Coordinators and provide care coordination services. Parents will be hired as the primary staff assigned to a child through a contract with ASK, elevating from advocacy to responsibility for coordination. Care Coordinators have authority to seek authorization, bill, and receive reimbursement. As with all care coordinators, there will be regular clinical supervision. At the service level, diffusion of the wraparound approach will mean that more parents partner in the care of their children.

Family support organization: ASK is the local Federation of Families chapter and currently discusses concerns, service needs and other issues with families, accompanies families to meetings with schools, court, protective services and mental health, holds a monthly parent support group meeting, publishes a bimonthly newsletter; and offers parent and some community training on different relevant topic areas (e.g., education law, behavior support). **Key Family Contact:** The Key Family Contacts for the system of care will be a total of 3.25 FTEs. The Director of ASK will serve as the Co-Principal Investigator/ Family, devoting 30% of her time. The Co-Project Director/Family will be hired by ASK. The additional 2.0FTEs will be parents hired by ASK and trained as Parent Care Coordinators. All Key Family Contacts will work with the Executive Director of ASK to provide advocacy, care coordination (as Support Coordinators/Assistants under Medicaid) and outreach to families of children not yet receiving services or receiving inadequate services. In addition, Key Family Contacts will oversee parent support group activities, gather data via phone calls and/or focus groups regarding family experiences and needs, and establish a parent mentoring program to match families with newly diagnosed children to more experienced families. Key family contacts, as well as other involved family members, will serve as representatives on governance bodies for the project. Attention will be paid to hiring staff reflective of the composition of the community.

Sustaining Family Involvement: As a part of the project, a Family Resource Center (FRC) located at and run by Advocacy Services for Kids (ASK), will provide a wide range of supports for family involvement in the broad spectrum of the system of care. A fund development campaign to support the FRC will take place during the grant period to increase community ownership and sustain the FRC beyond the federal funding period. Additionally, ASK will provide youth guided and parent provided services (e.g., care management, support groups) which are Medicaid reimbursable services. DHS, The Kalamazoo United Way, and KCMHSAS currently provide support to ASK. Future commitments will be secured during the project.

Parent Professional Partnerships: Pairing ASK staff as Co-Principal Investigator and Co-Project Director of this grant, as well as with the clinical professionals, will create a strong partnership

that will allow family members full access to planning, management and evaluation of the system of care. The Executive Director of ASK has a strong commitment to these principals stemming from her own experiences as a parent and understands the power of partnership, ownership, voice, and access. ASK will hire parents as staff to whom provide care coordination. Parents will provide training and receive training alongside with professionals. Training will include topics that will foster skill development of professionals and of family members in family driven care. Family members will be fully involved on all governance committees and will have enough “seats at the table” to make are real difference. Family members will also have the opportunity to individually evaluate services through satisfaction surveys.

Compensation for Family Members: KCMHSAS has provided compensation to youth, parents, caregivers and community partners since 1997; this practice has become part of the culture of Kalamazoo County. The project will implement strategies to fully engage and be more responsive to families and advocacy organizations of differing racial and ethnic minority backgrounds in part by assessing what supports and approaches will aide their participation.

Youth Guided Care: **Youth participation:** Youth have been part of the IAT meetings for 3 years. The Youth Coordinator will continue to work with youth to unite them into a forum, based on the Kalamazoo Youth Development Network model, a program offered by the local United Way. The United Way will provide training to assist youth in becoming their own advocates. The United Way also offers grant opportunities for developing youth groups, which could be used for long-term sustainability. The Youth Coordinator will work to assure youth are represented on the governance committees. The project will use the Youth Involvement in Systems of Care: a Guide to Empowerment (Matarese, McGinnis & Mora, 2005) to guide this process. Youth will participate in individualized plan through the care management process.

Youth Coordinator: The project is committed to hiring one or more youth to serve as a youth coordinator. ASK will work with the projects Co-Directors to recruit and support a youth in this role. Feedback from youth and young adults thus far included advice that they would be more comfortable working in tandem with another youth. The Kalamazoo Youth Development Network has also stepped forward to assist in the recruitment and support of a Youth Coordinator. The Network has experience in fostering youth leadership and participation.

Cultural and Linguistic Competence: A central goal of the project is to create policies, and procedures to assure effectiveness for diverse populations, to identify strategies to eliminate the disparities in access, utilization, quality of mental health services, and expand the availability of effective clinical interventions, for children and their families from all groups. Participants representing the diversity of the County planned and will govern the project. Three specific areas that have been identified as national issues are also concerns in Kalamazoo County: (1) In Kalamazoo African-Americans are over-represented in special education programs, juvenile justice systems, and community mental health programs (Callander, 2005, Weichlein, 2005, Santman, 2005). (2). Hispanic non-English speakers are less likely to seek mental health services (Wijnberg, 2004/2005. KCMHSAS has recently undertaken a state-funded study of barriers to Hispanic women seeking and receiving mental health services, which will inform project work. (3.) Gay, lesbian and questioning youth are 2-3 times more likely to contemplate suicide than their heterosexual peers. For our community surveys indicate that the suicide rate for GLBT youths is 8 times higher (Kalamazoo Gay & Lesbian Resource Center, 2005).

Under the auspices of the Cultural/Linguistic Workgroup, the project will support progress by:

- Cultural competency training will be required for all staff and contractors affiliated with the project (e.g. myths and misconceptions, understanding differences, institutional racism, building empathy and communication pathways, bias in assessment, etc.)
- Reach out to organizations including the Lewis Walker Institute for the Study of Race and Ethnic Relations, the Hispanic American Council, and Gay/Lesbian Resource Center.
- Network with local organizations to establish relationships. (e.g. ASK teaming with Parent and Adult Support Services which serves an African-American and Hispanic neighborhood.
- Social marketing will play a vital role in outreach, staff recruitment, reducing stigma, identifying collaborative organizations among Kalamazoo's ethnic and cultural groups.
- KCMHSAS currently uses a registry of language speakers and has a "Language-Line" contract. KCMHSAS employs bilingual speakers and a sign language interpreter.
- Workgroup will review policies, structures, practices, and procedures to assure that the delivery of services and supports are effective for diverse populations.
- Strategies will be developed to recruit and retain qualified diverse and culturally competent providers, leadership within the project, and child serving staff hired by provider agencies.
- Develop a strategic plan to expand array of culturally and linguistically diverse providers.
- Provide cultural consultation to system of care network, and on child/family-specific issues.
- Work with community organizations and churches to provide youth with SED with more recreational and social options.

The 14 Standards for Culturally and Linguistically Appropriate Health Care Services (CLAS 2001) and the checklist from the National Center for Cultural Competence at Georgetown University will guide the development of the Cultural and Linguistic Competency Workgroup's strategic plan. Key performance indicators will be developed and monitored.

Service Plans/cultural competence: All PCPs will be developed, implemented and revised based on cultural beliefs, practices, traditions, customs and norms of children, youth and their families. Each family own family culture will be respected. The inherent strengths and the resiliency of the child and their family will be the foundation of the plan. The family's role choosing who participates on their team will lead to the involvement of more natural supports and possibly supports who bring expertise/perspective on issues of culture. Family input regarding planning process (e.g. location, duration, leadership, and actual plan) enables respect for differences.

Culturally/linguistically diverse participation: The *Kalamazoo Wraps* project will continue to prioritize the meaningful participation and advocacy from culturally and linguistically diverse groups as it has in creation of governing body, **IAT**, workgroups, and the care review team.

Evidence in Management Plan: A Cultural and Linguistic Competency Consultant has been identified and will provide leadership to this project with the full support of the **IAT**. He is an experienced researcher on the roles that culture, race, and ethnicity have on utilization patterns.

The Director of the Kalamazoo Gay and Lesbian Resource Center, will also participate in the project, and the project will continue to reach out to organizations such as the Institute for the Study of Race and Ethnic Relations and the Kalamazoo Hispanic American Council for guidance. Training and coaching will be widely available. Efforts will be made to recruit and hire staff that are representative of the diversity of Kalamazoo County.

Expand service array: The Cultural Linguistic Competency Workgroup's strategic plan will address the need to identify a diverse network of contract providers, recruit and retain a diverse workforce, develop the capacity of provider organizations serving large numbers of minority families, but who have not historically been viewed as resources in the system of care. Modifications to Evidence-Based

Practices: The Evidence Based Practice workgroup will monitor the services and practices to ensure they are effective for the all cultural, racial, ethnic and linguistic groups. The Cultural and Linguistic Coordinator and the Clinical Director will contact experts and other sites to explore modifications. Family and community input will be sought and included. Cultural linguistic consultant: Dr. Lonnie Duncan will serve as Cultural and Linguistic Consultant. He will provide expert consultation to the system of care and its constituent organizations to establish and implement effective policies, practices, procedures, strategies, and structures.

Federal Law and Standards Compliance: All licensed mental health programs, contractors and employees are required to comply with Title VI of the Civil Rights Act. The Cultural and Linguistic Competency Workgroup will develop a comprehensive strategic plan (reviewed by the IAT) to address the 14 Standards for Culturally and Linguistically Appropriate Standards in Health Care Services (National Standard for CLAS in Health Care, 2001) and CMHS' Cultural Competence Standards (Cultural Competence Standards in Managed Mental Health Care, 1998).

SUSTAINABILITY

Linkages w/ reform/goals: Kalamazoo seeks to strengthen the local system of care for youth with SED by accelerating the local implementation of many of the objectives contained in national reports, including the President's New Freedom Commission (2003), the Surgeon General's report (1999) and Conference on Children Mental Health (2000). These reports outlined inadequacies of the current service structure (e.g., fragmentation of services between systems; lack of parent/youth input into system design/service delivery; need to build on family strengths; assure a culturally relevant context). The Michigan Mental Health Commission's report (2004) identified seven goals to transform Michigan's mental health system that are consistent with the findings in the New Freedom Commission Report. The goals of the project are the same as SAMHSA's goals/priorities for this initiative (expand community capacity, provide a broad array of services, ensure individualized service plans & culturally and linguistically competent practices, and promote family/youth empowerment). Specific objectives for each of the goals will be developed by the project team as part of the planning process. Find below several concrete examples of how project goals link with transformation/reform efforts:

- 1) The project will accelerate the implementation of several evidence-based/promising practices, including Positive Behavior Intervention Support (PBIS), and specifically link mental health services to the targeted intervention strategies in order to accomplish the goals in these reports. The local implementation of PBIS will be linked to Michigan's Integrated Behavior and Learning Support Initiative that is in turn linked to the National effort. Lucille Eber is an implementation collaborator with the national Center on PBIS and a national expert on PBIS and Wraparound. KCMHSAS is a member of Michigan's Evidence Based Practice Steering Committee.
- 2) Oregon model of Parent Management Training implementation will be in conjunction with the Michigan State Plan effort to require each Pre-Paid Health Plan to implement an evidence based project; KCMHSAS is the regional Medicaid Pre-Paid Health Plan. Marion Forgratch is the consultant to this project as well as the consultant to Michigan's statewide implementation plan. This model will be offered to **all** child/family serving systems/agencies in Kalamazoo County.
- 3) Increased, and in some cases, initial, attention will be given to inclusion of strategies to improve mental health services for minority populations in Kalamazoo and to address disparity of minority children placed in special education and juvenile justice programs.

- 4) Full development of a family resource center. Several of the services to be offered at the Family Resource Center are reimbursable activities under the State Plan for Medicaid Services. Additionally, the Youth Guided values are shared at the local level and funding and collaboration opportunities exist through the Kalamazoo United Way. The governance structure will help ensure project sustainability. For example, the Family Support Advisory Council will be linked into the governance structure and is a standing advisory committee of the KCMHSAS Board.
- 5) Integrated Co-occurring Treatment for Youth with Substance Abuse and Mental Health Disorders. The Michigan Department of Community Health has a statewide focus on development of co-occurring services. Locally, Kalamazoo is beginning to blend funding from mental health, substance abuse, and juvenile justice to create co-occurring services.
- 6) Directed Supervision is a model developed by Pat Miles to help communities infuse system of care values across providers within a system of care. Pat is also the national consultant to Michigan/Department of Community Health for the implementation of Wraparound statewide; she will help the project implement a model of change of direct service patterns through implementation of a supervision model that develops local transferable expertise.
- 7) Use of an assessment and treatment protocol for youth that utilizes screening, developmental pediatrics, occupational therapy evaluation for sensory integration therapy, neuropsychological assessment, and psychiatric services will become contractually required and monitored.
- 8) The project will utilize both the National Evaluation protocol and Michigan's CAFAS/Level of Functioning Project to measure effectiveness and will link to Federal and State transformation efforts. KCMHSAS is already involved in the state CAFAS Project and will continue.

Sustainability: The project's inclusive Governance model will guide system reform, including developing a comprehensive review of all resource allocations, development of a sustainability plan, and work toward developing creative and integrative finance strategies. Services with poor outcomes will be identified and a plan developed to shift these resources to evidence based practices. The project will identify opportunities to create efficiencies by eliminating those that are duplicative in order to create new efficient integrated services. For example, current psychiatric services are not provided such that school staff have an opportunity to learn about or report side effects of medication. Many children lack access to specialty medication services and families use their pediatricians in isolation of other efforts to help their child. Outpatient services have often provided parents with parenting strategies that left them feeling blamed and without effective strategies. The project will work with partners on identifying and building upon strategies to braid and blend resources to provide integrated services, including integrated service strategies for youth with SED and substance abuse and for youth with SED and school failure.

The local plan will develop a sustainable model of practice by maximizing resources allocated to the provision of mental health services across systems. Funding for mental health services is provided through multiple funding streams including Title XIX of the Social Security Act (Medicaid), Title XXI- State Children's Health Improvement Program, Michigan's Community Mental Health Services Block Grant Plan, and in the state Mental Health Plan for Children and Adolescents with Serious Emotional Disturbances. Federal entitlements include: Individuals with Disabilities Education Act, both Parts B and C, Family Preservation and Support Act, Title IV-A – Temporary Assistance for Needy Families Program, Title IV-B – Child Welfare/Family Preservation and Support Services, Title IV-E – Foster Care, Adoption and Independent Living.

Local funding is used for mental health, juvenile justice, child welfare, and in education. The project will braid these funds together through service planning that brings these services and resources together as a single collaborative plan for each youth. The project will also help families to successfully use services through private insurance by having the support of a system of care available. The project will use savings and other strategies to leverage additional state, local, and federal funds (e.g. Medicaid, 1915 C waiver, foundations, and grants). Transforming use of services funded will take place at the policy and practice levels. Non-federal match contributions are outlined above in Section B under Infrastructure Development.

Coordination w/ Federal Initiatives: KCMHSAS received a State interdepartmental agreement (Appendix 1) that the proposed System of Care will be included in Michigan’s Community Mental Health Services Block Grant Plan for FY06 and in the state Mental Health Plan for Children and Adolescents with SED, submitted under Public Law (PL) 102-321. Implementation will involve a contractual partnership. The project will coordinate, through the use of individualized plans, the services offered through federally funded initiatives. Kalamazoo currently uses these funds for wraparound care management services, specialty assessment, training, and for respite. The project will make and receive referrals from the Children’s Trauma Assessment Center that is part of the National Child Traumatic Stress Initiative (Appendix 1) The project and the Assessment Center will join efforts in community training for parents, community members, and professionals in mental health, schools, child welfare, pediatric clinics, and juvenile court. Kalamazoo does not have a Safe Schools, Healthy Students Program or Child/Adolescent Mental Health/Substance Abuse State Infrastructure Grants.

Sustainability Strategies: GRID (*IAT-Integrative Action Team, KRESA-Kalamazoo Regional Education Services Agency, KCMHSAS-Kalamazoo Community Mental Health and Substance Abuse Services, LEP-Limited English Proficiency, MPCH-Multipurpose Collaborative Body, PIHP-Prepaid Inpatient Health Plan. *BBA-Balanced Budget Act)			
Supports available to Kalamazoo Wraps			Future Supports
Local	State	Federal	Comments
Parent Management Training			-Evidence based service.
KCHMSAS Strategy initiated 2004, KCMHSAS funded.	Mandated Service Component 2005	Medicaid reimbursable mental health service	-Redirect from ineffective outpatient and reduced residential. -Medicaid reimbursable activities -Juvenile Justice and child welfare reimbursable as outpatient therapy.
Positive Behavioral Intervention Support			-Develop local expertise to support ongoing efforts, in kind offering between Education and Mental Health and a change in how “business” is done/school wide PBS.
KRESA* and KCHMSAS strategy to expand implementation. Margaret McGlinchey, Ph.D. housed at KRESA and is responsible for the Kalamazoo Region	State Board of Education Grant Michigan’s Integrated Behavior and Learning Support Initiative, for elementary schools. Margaret McGlinchey, Ph.D. one of four State Directors	Some educational and some mental health services are eligible for Medicaid reimbursement that may result from the PBIS plan.	-Intervention strategies for individual children continue as part of a joint education service through existing or 504 Plan or Spec Ed as replacement for strategies used pre 2004. Some services Medicaid eligible through KCMHSAS. -Allocate funding from ineffective outpatient and non-evidence based skill building services. Reallocation of educational funding for this prioritized service.

Youth Guided Services			ASK partnering with Youth United Way. Grants available. Some services offered can be Medicaid reimbursable as peer delivered/peer operated support -Inclusive practices in policy making, governance, and service deliver are established
United Way in kind support to initiative Youth on governance-MPCB, IAT. Link throughout the project	Value of Michigan's Mental Health Commission (2004)	Value of the President's New Freedom report (2003)	
Parent Resource Center			-501c3 status: eligible for Grants and increased local funding. Kalamazoo Youth United way grants a very strong possibility for youth role funding. -Inclusive practices in policy making, governance, and service deliver are established -Shift funding from reduced residential and ineffective outpatient services -Fund services using available funding streams, e.g. Medicaid
Current KCMHSAS funding.	DHS Strong Families/Safe Children current funding	Services offered can be Medicaid reimbursable: wraparound as a Medicaid Supports Coordination, and Medicaid B3 services of Family Support and Education, and Peer Delivered or Operated Support Services	
Service Evaluation			-Will expand local participation in the CAFAS evaluation pilot. Use national required and local CAFAS; -Use of Kay Hodges as consultant; -Use results from local, state, and National Evaluation Plan to demonstrate effective and ineffective services and use data to determine which services should expand and which should be reduced/eliminated
Expand Participation in CAFAS Pilot. KCMHSAS has a quality plan.	CAFAS Pilot, EMU Kay Hodges is the consultant for this State of Michigan sponsored project	Use mandated National Evaluation Plan.	
Established Values and Philosophy			-Provider Network activities to include value philosophy requirements contractually. Incentive based contracting. -Required training-ongoing. -Wraparound fidelity monitoring. -Local "champions" of values and philosophy.
KCHMSAS plan as endorsed by MPCB	Some elements in common with State Education /IEP and State Mental Health Person Centered Planning	Some elements in common with Federal Education/IEP/504 and Federal Rules for Michigan Mental Health Person Centered Planning and B3 services	
Cultural and Linguistic Competence			-Assure via contracts, policies and procedures that services established and provided are culturally and linguistically competent. -LEP requirements. -Assure workforce and leadership is diverse, reflective of the community, and has the attitudes, knowledge, and skills to provide effective services. -Inclusive practices in policy making, governance, and service deliver are established.
Project committee. LEP requirements. Weak area for Kalamazoo. Few service providers outside of public employees mirror the population and linguistic composition of the community.	Value established in Michigan Mental Health Commission. Part of State Contract to PIHP.	Value established in President's New Freedom Commission. Medicaid and BBA requirements support.	
Directed Supervision			-Will develop local expertise and replicate skills throughout the service network. -Contractual requirement for service providers: values and strategies for service providers
KCHMSAS strategy to support/integrate. Pat Miles to be a project consultant.	Pat Miles is National consultant to Michigan for Wraparound		

Substance Abuse Services: Integrated Treatment Model - Ohio			
State and local tax revenue, local county child care funds.	Allowable state general fund via mental health as is a dual diagnosis service	Medicaid reimbursable service through PIHP.	-Current research project as an emerging best practice. -Blend Substance Abuse and Mental Health fund sources for Access, Assessment, and Treatment. Shift funding from duplicative silo-based outpatient treatment into non-duplicative co-occurring treatment.
Financing			
Local commitment to system of care. Many local services funded via PIHP*: Title XIX of the Social Security Act (Medicaid), State and Local Contract. Local child care funds for juvenile justice and child welfare. Local funds for Educational Services	Title XXI- State Children's Health Improvement Program. Jim Wotring, Director of Children's Services, Department of Community Health as State/Local Liaison	Individuals with Disabilities Education Act, both Parts B and C Title IV-B – Child Welfare/Family Preservation and Support Services, Title IV-E – Foster Care, Adoption and Independent Living Family Preservation and Support Act, Title IV-A – Temporary Assistance for Needy Families Program,	-Utilize Expertise of Jim Wotring, State /Local Liaison. -Blend and Braid funds. -Eliminate/streamline duplicative care management services. -Strengthen family and youth involvement so effective , culturally competent services are provided sooner, avoiding long, expensive and ineffective services. -Re-direct funding used for ineffective services (residential, skill building, silo case management services, isolated psychiatric/ outpatient services) to evidence based and effective services that are part of an integrated comprehensive service plan. -Apply for 1915C waiver as currently available in Michigan. Leverage additional federal funds, grants, and foundations. -Active planning for sustainability from 1 st day of project by responsible workgroup.
Sensory Integration			
KCHMSAS plan, local service Algorithm established.	Occupational Therapy is a required service component in State Contract for community mental health & education rules	Occupational Therapy is a required service component requirement in Federal Contract for community mental health and in education rules. Federal Medicaid reimbursable activity	-Current research project with Western Michigan University will indicate outcomes of use of SI for youth with SED. -Integrate services provided through mental health, physical health, and education.

This project aims to implement the strategies described in this application to bring about effective and efficient services. Aside from the positive effects on the lives of children and families, it will result in the ability of partnering agencies to better target funding and leverage additional state, local, and federal funds. For example, local funds will be pooled to leverage funding through 1915 C waivers. Local, state, and national grants/foundations will be pursued. This project will result in more children becoming eligible for public mental health services and KCMHSAS is required to provide services without waiting lists. KCMHSAS and partnering agencies of *Kalamazoo Wraps* see that in order to meet the needs of children with SED, the community will need to jointly invest more in services. Those funds will be identified through strategic planning and will likely come from a 1915C waiver, Medicaid revenues, State Plan and Federal Mental Health Block Grants through braiding with other public fund sources. Additionally, more children can be successfully served through private insurance when the support of a system of care is present.

SECTION C: PROJECT MANAGEMENT AND STAFFING PLAN (Also see Appendix 6)

Applicant Organization: Kalamazoo Community Mental Health and Substance Abuse Services (KCMHSAS) is the applicant organization. In 2002, KCMHSAS was designated by the Michigan Department of Community Health as a Medicaid Managed Specialty Supports and Services Prepaid Health Plan for a four county region, and in 2004 became the Regional Substance Abuse Coordinating Agency for the same counties. KCMHSAS serves as the single point of entry into the county-sponsored service delivery structure for priority populations for both children and adults. As one of 18 statewide Prepaid Health Plans, KCMHSAS is in a leadership position to promote benefit's availability and administrative structure that promotes system of care development. As manager of mental health, substance abuse and developmental disabilities benefits, KCMHSAS provides or contracts with all providers for these services and has extensive working relationships with all community health and human service systems, including formal service coordination agreements with the Department of Human Services, Kalamazoo Regional Education Service Agency, and the Circuit Court Family Division, which jointly fund the existing Wraparound project. Examples of contracts with child and family serving mental health agencies include Family and Children's Services, Michigan Addictions and Prevention Services, Children's Trauma Assessment Center and multiple specialty service clinics/individuals. These agencies/individuals also have contractual relationships with the all other state child and family serving systems. KCMHSAS, Department of Human Services and The Kalamazoo Greater United Way currently provide funding to Advocacy Services for Kids. KCMHSAS has a clear understanding of gaps and has begun partnering with other systems in the neurobiological classroom project and in the cross system Wraparound project. The commitments by KCMHSAS and the Kalamazoo community to the transformation of the system of care, through *Kalamazoo Wraps*, are reflected in the MOUs included in Appendix 1.

Qualifications/Experience/Time on Project (%): KCMHSAS is committing to pay for backfilling existing positions and provide staff to complete job responsibilities for staff who will be moved to the project full or part time. **Patricia Weighman, ACSW, CSW**, KCMHSAS Deputy Director of Children's Services, will serve as the **Principal Investigator (35% in-kind)**. Pat has 18 years experience specializing in children's mental health and implementing systems of care and currently spends 100% of her time devoted to the needs of children with SED and their families, with activities including development and maintenance of the provider network system serving children with SED and overall responsibility of budget. **Sandy Roethler**, Executive Director of the local family advocacy organization, Advocacy Services for Kids, will serve as the **Co-Principle Investigator/Family Empowerment (30%)**. Sandy is the mother of a child with SED, spent 4 years extensively researching/advocating for children's mental health and spearheaded a parent-led initiative to create a therapeutic classroom in the public schools. **Michelle Houtrow MA, LLP**, Children's Services Supervisor, will serve as the **Co-Project Director/Administrative (100% in-kind)**, has 10 years of experience working in the mental health field, specializing in children's mental health with a focus on Wraparound, and system of care development. **Pamela Pellerito, MA LLP**, Children Services Supervisor, will serve as the Project's **Clinical Director (80% in-kind)**. She is a Psychologist with more than 20 years experience working with children and adults with serious mental health issues, specializing in assessments, and is one of three clinical specialists in the County recognized as an expert in sexual offender assessment and treatment. She currently supervises school-based services, juvenile justice diversion and the recent infant /early childhood mental health initiative. **Lonnie Duncan, PhD.**, Assistant Professor Western Michigan University and Licensed Psychologist,

Cultural and Linguistic Competency Consultant (25%), is actively involved in minority mental health through teaching, research and practice and has conducted research on the roles that culture, race and ethnicity have on the usage of and attitudes towards mental health services. **Jim Wotring, MSW**, Director, Michigan Office of Children’s Mental Health Services, will serve as **State-Local Liaison, (10%, in kind)**. Jim will serve as the bridge between the State and the project to realize sustainability, offering his expertise of financing mechanisms to establish collaborative and integrated funding investments. His efforts will include assistance in the development of interagency agreements for a sustainable system of care. Existing **Early Intervention Consultants (3.2FTE in-kind)** will change their current focus to implement specialty assessments, treatment protocols and referrals to evidence-based interventions primarily in the schools for the project. **Dr. David Hartmann**, Director of Kercher Center for Social Research (.075FTE) and **Dr. Rachel Bridges Whaley**, Associate Director (.175FTE) will serve as the lead evaluators. Both have extensive training and experience in both quantitative and qualitative research methods and have multiple experiences serving as evaluators for large national evaluation projects related to mental health and children. **Dr. Victoria Curtis (1.0FTE)** has extensive expertise in health care systems with emphasis on family access, public health policy, and gender, race, and ethnic studies. Research Assistants, students, parents and youth (.75FTE).

Staff to be hired: The project is committed to hiring staff who are dedicated to system of care values, are ethnically diverse and representative of those to be served. All staff will participate in cultural competency training annually to assure acquiesce of the essential awareness, knowledge and skills to exemplify respect and sensitivity to the unique cultural issues of those served. FTEs to be hired: Co-Project Director Family (1); Parent Care Coordinators (2); Social Marketing (.50); Evaluation Staff (1); Technical Assistance (1); Wraparound Care Coordinators (2); PBIS Coordinator (1); Integrated Co-occurring Treatment (2); Youth Coordinator (1); Intake /Discharge Specialists (1.80); Training Coordinator (1); School Based MH Consultant (.80); Contracts Manager (.50); and Support Staff (1). National experts who have committed to work with the project as **Key Consultants: Lucille Eber**, Positive Behavioral Interventions and Supports (PBIS); **Kay Hodges**, Child and Adolescent Functional Assessment Scale (CAFAS); **Pat Miles**, Wraparound and the Directive Supervision model; **Rick Shepler, Ph.D.** and **Patrick Canary, M.Ed.**, developers of the Integrated Co-occurring Treatment for Youth with Substance Abuse and Mental Health Disorders. Other local and state experts who will **consult** to project:

EXPERTS	TITLE/AGENCY	AREA OF EXPERTISE
Dr. John Board	KCMHSAS	Developmental Pediatrics
Dr. Mark Sloane	Michigan State University/Kalamazoo Center for Medical Studies	Developmental Pediatrics
Karen Galloway	Kinetic Kids, LLC	OT and Sensory Integration
Scott Moyer	KYD NET	Youth Development
Denise Hartsough	United Way	Community Development
Margie McGlinchey	Michigan's Integrated Behavior and Learning Support Initiative	Positive Behavioral Supports & Interventions
Marion Forgatch	Senior Research Scientist	Parent Management Training Oregon
Luann Gray	KCMHSAS Children’s Supervisor	Parent Management Training Oregon
Chuck Spence	KCMHSAS Substance Abuse Director	Substance Abuse/Alcohol Treatment
Dr. Lonnie Duncan	Western Michigan University	Cultural & Linguistic Competency
Ed Sova	KCMHSAS Information Systems	MIS Consultant
Jodi Smith	KCMHSAS Senior Financial Analyst	Fiscal Consultant

Charles Thomas	KCMHSAS Discharge Planner/SED	Intake and Referral Specialist
Sharon Repkey	Gay & Lesbian Alliance	Cultural & Linguistic Competency
Dr. Jim Henry	Children's Trauma Assessment Center	Children's Trauma
Steve Clomon	9 th Circuit Court-Family Division	Juvenile Justice, Drug Court

Tasks/Staff/Timelines/Feasibility: Structure/Oversight: Several specialty workgroups, which will be co-chaired and staffed utilizing local, state and national expertise, family leadership and youth involvement, will be established by the Co-Project Directors, who will ensure project wide coordination. The Co-Project Directors will be responsible for monitoring each workgroup's plan to ensure focus on the project's overall goals and desired outcomes, through use of strategic plans and logic models. They will be supported by the Principal Investigator/Co-Investigator, Family Member and the IAT. The Co-Project Director /Administration will be responsible for overseeing all project activities related to administration, including hiring procedures, office procedures, project activities, and the oversight, management and coordination of all strategic planning with a focus on sustainability. The Co-Project Director/Families will be responsible for oversight of project activities related to youth and family development including the Family Resource Center, Parent Care Coordinators, Cultural/Linguistic Competency and Social Marketing. Both will interface with SAMHSA, the evaluation team and the specialty focus groups. **Project Support:** The Technical Assistance Coordinator will provide support for strategizing and assessing the technical assistance needs of the project. The Social Marketing Coordinator will provide support in the development of a comprehensive social marketing /communication strategic plan for the community and will interface with the national communications campaign contractor. Both of these coordinators will participate on the specialty workgroups to ensure that all of the technical assistance and social marketing issues are incorporated into the project's strategic plan beginning in Year 1 and continuing throughout the project. These staff will work with the specialty workgroups to identify specific technical assistance, social marketing and cultural competency needs necessary to develop a coordinated system of care. The **overall general timelines** are: Year 1: Planning. Develop objectives to fully implement each goal; Year 2: Implementation of services and research sustainability. Year 3: Full implementation of services and beginning to review evaluation data. Year 4: Review evaluation data and revise strategies related to sustainability, begin transferring and sharing responsibility with partners. Year 5: Identify funding streams that can be redirected (e.g. local, regional, state, foundation & private) and begin transition to graduate community site status. Year 6: Fully engaged sustainability plan, write progress reports and celebrate full transition to a comprehensive system of care. Annual tasks include: review and update of: the overall strategic plan and logic model, the evaluation plan and results, the sustainability plan, the status of the cultural and linguistic competency measures, social marketing and training plan, the ongoing training plan of project staff and partner agencies, compliance with SAMHSA requirements, social marketing strategies, and of the quality assurance measures, and taking time to celebrate successes and changes. Between competent administrators, use of local, state and national experts, coordinated workgroups and a collaborative spirit across all involved, KCMHSAS and Advocates for Kids believe it is **feasible** and almost assured that the project can achieve the desired outcomes.

SAMHSA Goals: *Expand Community Capacity, Provide Broad Array of Services & Individualized Service Plans: **Project Outcomes:** Implement Evidenced-Based Practices & Cross System Use of Same Screening/Treatment & Support Protocols: Year 1, workgroups will:*

- 1) Pursue development, training and implementation of the identified evidence-based/promising

practices, developmental pediatrics and school-linked psychiatry; 2) Develop and implement culturally competent protocols for screening/treatment/specialty assessments; 3) Develop a strategic training plan to ensure cross system staff understanding, knowledge and proficiency of use of interventions, supports and tools; 4) Utilize focus groups to gather feedback and strategies to better serve minority populations; 5) Begin planful modifications after gathering information from focus groups and other SAMHSA sites. In year 2, all enrolled youth screened for substance abuse. Clinical Director will co-chair the Evidenced-Based workgroup, with focus to assure the intervention's proven efficacy for the cultural, racial, ethnic and linguistic groups represented. The cultural assessment of services will be completed and evidenced-based interventions will be adjusted /strengthened as needed, and will be implemented for the target population. During years 2-6, service utilization, ongoing training for the protocols and sustainability will be the focus. **Project Outcome: Strong Infrastructure for County Wide System of Care in Place;** Year 1, the MPCB, IAT, specialty workgroups and the Family Advisory Council will be functioning with the focus on developing an infrastructure that is representative of the diversity of the persons served. Additional members, parents, youth and diverse advocacy representatives, will be added to the Integrative Action Team. The MIS will begin linking child-serving systems for the integration of evaluation and quality assurance. In year 2, the Sustainability/Fiscal/Transformation workgroup will specifically be charged with identifying and pursuing development of additional funding streams and with blending/braiding existing funding streams. They will review and improve the linkages and coordination of all parts of the system of care. In year 3, a countywide satisfaction and feedback survey will be implemented and used to assist with long term sustainability.

SAMHSA Goal: *Individualized Service Plans*: Project Outcome: County Wide Individualized Wraparound Model Implemented: Beginning in Year 1, a specialty workgroup, co-chaired by the Co-Project Directors will develop the Care Review Team and the strategic action plan. This group be fully functioning by the third quarter and will provide oversight to the Technical Assistance sub-group. Staff will be hired and trained to provide Care Coordination (e.g. Wraparound Care Coordinators, Parent Care Coordinators, School Based Consultants and Integrated Co-Occurring Treatment Home Based Clinicians). Also in Year 1, the Directive Supervision model implementation will begin with mental health system providers. In Year 2 lead agency staff for multiple child serving agencies will be identified to participate in Wraparound training, with an emphasis on individualized service plan development and delivery. Directive Supervision training will be made available to additional human service supervisors. In Years 3-6 lead agency workers will be providing Care Coordination services throughout the system of care that is consistent with the wraparound model and system of care values. Ongoing training will continue for established staff as well as new hires.

SAMHSA Goal: *Culturally and Linguistically Competent Practices*: Project Outcome: Specialized Cultural & Linguistic Practices Implemented: Beginning in Year 1, Cultural and Linguistic Competency workgroup, will be established by reaching out to include representation from diverse advocacy groups, such as the Kalamazoo Gay and Lesbian Resource Center, an expert in minority health from Western Michigan University, Hispanic American Council and the Hispanic Leadership Coalition of Kalamazoo. This group, chaired by the Cultural and Linguistic Competency Consultant Dr. Lonnie Duncan, will focus on guiding the system of care in implementing strategies that assures service providers possess the attitudes, knowledge, and skills to effectively serve children and their families. A cultural self-assessment of services will

be done utilizing the CLAS plan. In year 2-6, this group will be charged with assuring that contract language is implemented to assure diversity and cultural competency in program implementation and assess, then develop a plan to address disparity of minority youth in juvenile justice placements. This group will work closely with the Social Marketing Coordinator to identify strategies to assist with marketing, reaching out, welcoming, engaging and sustaining family participation at all levels of the project. Strategies will be identified and implemented to attract a more diverse workforce within the system of care and in leadership.

SAMHSA Goal: *Promote Family/Youth Empowerment:* **Project Outcome:** Family & Youth Partnerships Realized with all Agencies: Year 1, the Family Support Advisory Council, chaired by the Co-Project Director/Family Empowerment, will provide support to the Parent Care Coordinators, Youth Coordinator(s) and the Family Resource Center. Additional parents (2) and youth (2) will be added to the Integrative Action Team as well as represented on each specialty workgroup. Year 2 parents will begin providing trainings in partnership with service providers and trainers. Year 3-6 youth and parents will be trained as spokespersons and participate in the social marketing plan geared toward transformation and sustainability. The Youth Coordinator will work with additional Executive Team members in the development of a strategic plan to incorporate youth voice, ownership, and access into all elements of the system of care.

Pertains to all **SAMHSA's Goals:** **Project Outcome:** Extensive Cross System Training Realized: Year 1, extensive cross training will be a focal point in the strategic planning and logic model development to assist in the implementation and achievement of the desired outcomes of this project. Providing training to the project staff will be prioritized throughout the grant. Staff will participate in training through direct instruction, retraining and by providing mentoring to new hires. This will begin in the first year and continue in Years 2-6.

Facilities: Project staff will be split between Advocacy for Kids (ASK), which is located in downtown Kalamazoo, a racially mixed and high poverty area, and the offices of KCMHSAS, which is located on a frequently used bus line. KCMHSAS is exploring co-locating with ASK in the downtown location. Currently, Wraparound Care Coordinators are housed in the 9th Circuit Court Family Division building. The existing Integrative Action Team (**IAT**) has begun work to acquire offices for the additional Care Coordinators for the project throughout additional agencies such as Michigan Human Service Department, ASK and KCMHSAS. Community relationships will continue to expand and develop by providing services to families within the community settings of their choice (e.g., library, advocacy centers, and churches). The Co-Occurring evidence-based project will be located at Family & Children Services, a local agency providing multiple child and family community-based services through both child welfare and mental health. School staff will be in various schools. The project will need to purchase many equipment items for project staff (e.g., most office furniture, phones/cell phones/fax, computers, copy machine). The existing KCMHSAS MIS is secure, networked and Windows capable and it can generate and receive HIPPA compliant billing. KCMHSAS, Education, Court and Child Welfare will all donate some office furniture, including locking file cabinets.

ADA/Cultural: KCMHSAS is ADA compliant and requires ADA compliance of all contractual providers, and maintains policies and training requirements regarding Limited English Proficiency, Visual Impairment and Communication Accommodations, Accessibility & Accommodations, Recipient Rights and Cultural Diversity. KCMHSAS contracts with three interpreter resources, which provide assistance in 150 languages by phone, 36 languages, including American Sign Language, by face to face, contact. In all aspects of the project's staffing, location,

space, service delivery and evaluation, the program will reflect the cultural and ethnic diversity of those served and will engage representatives to serve on different committees and hire representatives for different tasks (e.g., evaluation, family advocates) towards ensuring these ends. Materials for families, meetings and services will be adapted to accommodate the language and special needs of families. Regular appraisals of services, sites and staff will be conducted through the Cultural/Linguistic Committee and the new Care Review workgroup to ensure that families of all ethnic groups feel welcome and comfortable and that their unique strengths and values are recognized. The Cultural/Linguistic workgroup will provide input to the development of the Family Resource Center and any outreach centers established. All new locations will be sited in locations representing minorities and convenient to public transportation or frequently used venues (e.g., schools, community centers) The unique cultural and other characteristics (e.g., sexual orientation, hard of hearing, sight impaired) of all served will be respected and reflected in each locale (e.g., decor, pictures of people portrayed in materials).

HIPPA: KCMHSAS is a Covered Entity under HIPPA, has Privacy, Security and Corporate Compliance Officers to oversee activities related to HIPPA adherence. All reimbursement activities related to invoices and billings through electronic transmission are HIPAA compliant. Policies and procedures for each HIPPA regulation have been transmitted to all staff and provider agencies and training and education is monitored for all network providers for timeliness and adherence to policy. The project specialty group established to develop the new integrated MIS system will include Privacy and Security Officer representation, ensuring HIPPA compliance. Protected health information of all service recipients is ensured by adherence and monitoring of compliance by quality assurance staff. Training will be provided to project staff in the new programs and all consultants regarding HIPPA regulations and procedures, and regarding confidentiality standards within 30 days as per KCMHSAS policy and procedures.

SECTION D: EVALUATION PLAN

Evaluation Activities: The Evaluation Team at the Kercher Center for Social Research (KCSR) at Western Michigan University is committed to complying with the requirements of the National Evaluation and engage in all requested/required activities. Members of the team will participate in the training and technical assistance sessions throughout the funding period, implement procedures in timely manner and in accordance with requirements for data collection, data entry, data management and storage of data. The Team will utilize the standardized forms that are part of the National Evaluation and will conduct baseline assessments, assessments during treatment, and assessments following termination (i.e. longitudinal outcome study), and send reports and data to the National Evaluation as required and in a timely manner. The Team has experience complying with other National Evaluations for many other projects including Building Restorative Communities, Drug Courts, and Co-Occurring Disorders where team members have participated in trainings, standard and on-line reporting and data collection.

National Evaluation Data: Data derived from the National Evaluation will be shared with local, state, and federal stakeholders in order to improve the service system, increase the quality of service delivery, develop systems of care policies, and make possible the sustainability of the system of care. For example, baseline data collected at study enrollment and intake will be evaluated to make sure that recruitment from the target population is successful. Problems with recruitment in year 1 can be rectified for year 2 to ensure compliance with the grant goals. Data collected during treatment on service utilization, program fidelity, and client outcomes will be

shared with key stakeholders on a timely basis and used to identify ways to improve the service system and the quality of service delivery during year 1 and in subsequent years. Local key stakeholders will utilize the data collected via the National Evaluation to develop relevant policies to enhance the service system and quality of services. Data will also be used to help local stakeholders make decisions regarding the maximization of resources and the elimination of redundant services to foster the sustainability of the improved system of care.

Evaluator Knowledge/Experience: The evaluation team consists of David Hartmann, Professor of Sociology (Ph.D.) and Director of KCSR and Rachel Bridges Whaley, Assistant Professor of Sociology (Ph.D.) and Associate Director of KCSR. Dr. Hartmann has approximately 50 refereed articles and book chapters, 160 sponsored reports on evaluation and other topics, and approximately three million dollars of grant support in the past 15 years including evaluation projects on substance abuse and co-occurring disorders among children and on child and adult mental health programs. He is past editor of the *Journal of Applied Sociology* and regularly publishes in the areas of evaluation methods, statistics, substance abuse, and urban sociology. Dr. Whaley has 6 refereed articles and book chapters, a community research report, and numerous professional association conference presentations. She has over 14 years of research experience include 6 years of managing and supervising data entry, data management and data storage, and conducting analyses to test hypotheses for two longitudinal randomized intervention trials designed to reduce conduct disorder in children. Dr. Whaley is currently overseeing the evaluation of a collaborative community project designed to reduce risk factors for juvenile delinquency in the county. For that project, she works with community members, service agency representatives, and elected county officials. Both Drs. Hartmann and Whaley have extensive training and experience in both quantitative and qualitative research methods; both teach or have taught research methods and statistics courses at the undergraduate and graduate levels. Hartmann and Whaley will have primary responsibility for designing and supervising the evaluation plan, analyzing results, and report writing while day-to-day supervision of research team members (e.g., family members, research assistants), data collection, data systems maintenance, and work with the staff and committees of *Kalamazoo Wraps* will be undertaken by Victoria Curtis (Ph.D.)(1.0 FTE). Dr. Curtis' areas of expertise are in medical sociology, knowledge of health care systems with emphasis on family access, public health policy, gender, race, and ethnic studies, and qualitative/quantitative methods. She is also a registered medical laboratory scientist. Dr. Curtis has directed field operations for medical and mental health research projects and worked extensively with mental health clients and their families in both clinical and research settings. Most recently she was the project director on a two-year grant based research project that examined health care practices among adults and children enrolled in a community health plan. In addition to coordinating data collection processes, her role as co-investigator required interviewing a number of participants who were medically diagnosed and treated for a mental health component of the continuum of care. A strength of the KCSR is that staff members have traditionally included African Americans, Spanish speakers, and members of other racial ethnic minority groups. The Evaluation Team will ensure that this trend continues with this project. For example, we will employ bilingual research assistants as needed. Furthermore, employee training at the KCSR includes attention to cultural sensitivity in all aspects of the research process including interview techniques. The Team has access to persons trained in translation and interpretation in the Foreign Languages Department at WMU whom will be hired to translate forms and act as interpreters when non-English speaking persons are enrolled in the study, of such persons have been utilized in previous studies at the KCSR.

Facilities/Equipment: Space will be provided the KCSR for all evaluation activities. As is the KCSR's practice, evaluation records will be maintained in secure, restricted access, and redundantly maintained databases, and will be regularly backed up with identifying information stripped from substantive data records. The equipment, software, physical environment, and personnel training and policies are all state-of-the-art and in full compliance with federal regulations and with Western Michigan University's IRB requirements. There are at least seven IBM compatible computers (both desktops and laptops) that can be utilized for this project; all have more than sufficient power, hard-drive storage, and RAM. Some are hardwired for the internet and others are wireless (WMU is a wireless campus). There is myriad software with unique and overlapping capacities including software for data entry (Access, Excel, MS Word), for data analysis (SPSS, AMOS, and SAS for quantitative data, and Nudist for qualitative data), for telephone interviewing (CI-3), and for data reporting (Access, Excel, MS Word), and a scanner with optical recognition capabilities. All files will be backed up daily using either jazz drives, zip drives, or high speed drives that attach via USB ports. KCSR has two locked rooms with high-speed computers, a locked graduate assistant office used for supervision and data analysis activities, a large locked workroom that houses reference material and filing cabinets with space for work, seminar rooms to conduct focus groups/interviews, and private offices.

Data: entry/storage/management/analysis/reporting: Access will be used to create electronic data entry forms that visually mimic agency forms and other paper and pencil data collection instruments which reduces data entry errors. Assistants will enter data using these forms, using double entry verification procedures. We will explore direct electronic access to the data collected with the CAFAS instrument and have multiple levels of security in all systems such that data entry personnel cannot accidentally delete files or overwrite existing data files. All electronic data will be stored on hard-drives and will be backed up daily to ensure no loss of data during any system failures. All paper forms will be stored in locked filing cabinets in the KCSR. The project director will oversee all data management including data cleaning, data entry, and instrument organization (forms will be labeled with short names that will connect hard paper forms to data files to reporting forms). The project director, principal investigator and co-investigator will conduct sophisticated analyses and will oversee more simple analyses conducted by graduate assistants. Specific analyses will be tied to level of measurement of the data; we will conduct descriptive analyses and will test hypotheses concerning group differences and change over time as relevant. For example, chi-square tests will be conducted to examine the effect of treatment type on outcomes (success versus failure). While T-tests and Analysis of Variance will be used to examine the effect of treatment type on mental health functioning (measured in terms of scales using the CAFAS instrument). We will use Access to produce reports that include both qualitative (e.g., staff observations on program fidelity) and quantitative data (e.g., number of staff trainings completed, percent of staff trained, percent of children successful, percent of children enrolled in different treatment types, etc.). Access can produce user specific forms as needed. We will also create reports using MS Word, and will report some results in the form of tables and figures using Excel or SPSS. To protect the confidentiality of all research participants (children, parents, staff, agencies), we will use codes instead of names or other identifying information (a master list of codes will be stored in a locked filing cabinet in the Principal Investigators private office). We will also follow suppression rules in reporting results to protect confidentiality, during ongoing monitoring and reporting stages, taking care to only report individual level findings for groups that are sufficient in number. If there is only one

member of a certain racial ethnic group, we will suppress information that could lead to the identification of that person until we have data for a sufficient number of members in that group, following suppression rules set by the U.S. government. Data will be stored in locked file cabinets in secure offices in the KCSR for three years following the end of the funding period.

Existing MIS systems: Child-serving agencies will submit data to a state-sponsored evaluator using the Child and Adolescent Functional Assessment Scale (CAFAS). Through CAFAS, monthly reports and tables will be produced that identify youth who are not progressing at adequate levels, monitor at-risk youth, and review treatment plans and suggest alternative plans (Hodges & Wotring, 2004). The evaluators will assist throughout this process and especially with the interpretation of reports that can inform the improvement of the service system and can increase the quality of service delivery and other key goals. Additionally, the evaluators will identify information gaps and needs and will assist the applicants in improving the collection of standard service related data as relevant. To the extent that the development of shared forms is needed, we will assist the applicants in such a task. In terms of administrative data, billing is currently integrated using HIPPA compliant billing and reimbursement mechanisms. KCMHSAS utilizes Windows-based computer systems and a programmable information system.

Family/Youth: The project is committed to making the mental health system-of-care family and youth centered. The evaluation team is committed to hiring and training parents and youth in basic research methods and involving them in aspects of the design of the evaluation, at stages of data collection, and in the interpretation and reporting of results. Families will assist in the development of instruments to measure outcomes related to family satisfaction and functioning; parents will conduct interviews with agency staff; and parents will assist in the presentation of results to varied forums. The project will strive to hire families from multicultural groups.

Local Evaluation Activities: The local evaluation plan will address four areas of activity (see below), with all areas combining qualitative and quantitative methods with community members actively involved in semi-structured interviews as well as in authentication of measurement dimensions and protocols. The plan as a whole is based on a quasi-experimental logic wherein Kalamazoo County changes are compared both to the county's history and to other counties selected on the basis of demographic and service mix comparability. Participation in CAFAS provides standardized reporting of process and outcome measures across Michigan counties and so facilitates rigorous comparisons. In all cases, change scores will be based on baseline measurement and repeated measures at three-month intervals during treatment and at least one year after discharge from grant supported services. When necessary forms will be translated into appropriate languages and interviews will be conducted by bilingual research assistants or with the aide of an interpreter. Interviewers will be trained in culturally sensitive interviewing practices. The CAFAS instrument has been shown to be reliable and valid for multiple demographic groups. Instruments under development will be examined for their cultural sensitivity and relevance, and reliability and validity for multiple demographic groups.

1. Outcome assessment. Proximal outcomes (i.e., short term or most immediate/close outcomes) for the **system-of-care** will include access to services for the target populations, the range of services recommended and accessed, and the heterogeneity of the care plans produced for clients. This last dimension reflects the initiative's desire to have meaningful family involvement and cultural sensitivity in the planning process. While these process dimensions will be measured directly in section 3, they should also be demonstrable in holistic individualized plans in opposition to a one-size fits all model. Short and long term outcomes for

children, measured at the client level but aggregated to rates for purposes of county level comparisons will include out of home placements, development of co-occurring disorders, criminal justice system involvements, hospitalizations, school suspensions, educational attainment, and educational performance (i.e., grades). A key piece of the local evaluation effort involves the participation of service agencies in the state-sponsored evaluation that utilizes the CAFAS. CAFAS has many uses including data collection, treatment needs assessment, an a pre and post treatment instrument, a tool for ongoing case management and monitoring, a strengths and needs assessment, and an agency monitoring and tracking device. Included within CAFAS is a scale that measures mental health functioning along 8 dimensions: school/work role performance, home role performance, community role performance, behavior toward others, moods/emotions, self-harmful behavior, substance use, and thinking. Myriad outcome data for children and the system as a whole are available in the form of reports and figures. One such report is the Baseline Assessment Report which presents for each client, diagnoses, scores on the 8 dimensions of the CAFAS Scale, overall level of dysfunction, youth risk behavior (e.g., suicide attempts, harmful behavior, runaway behavior, psychotic symptoms, and severe substance use), service dependency, and rater, parent, and child comments on degree of impairment, family strengths, and treatment or care needs. Another report is the Baseline Treatment Plan Report which details the description of problems or strengths for each of the 8 dimensions of functioning and outlines the treatment plan devised to address problems or to capitalize on strengths. Both reports are available at intervals during treatment and allow for analysis of change in all areas from overall CAFAS score, to specific functioning dimensions, to treatment plans and care needs. Charts and figures can be produced for individuals and for aggregates based on demographic group, treatment modality, diagnoses, and other classifications as needed.

Other client based mental health functioning measures including the MAYSI 2 for substance abuse and other mental health functioning and additional measures generated by specific interventions will be collected and monitored, tracking the extent to which the applicants implement Positive Behavioral Interventions and Supports (PBIS) in targeted schools. PBIS has a pre and post measurement tool that examines program fidelity and outcomes such as number of office referrals and suspensions. We will review the use of and the findings from the screening, treatment and support protocols that the applicants are currently developing to be shared across agencies to identify ability level and its effect on a variety of domains. Key among our activities will be the assessment of the predictive validity of the components of this tool for behavioral and mental health functioning outcome changes as well as the cross-system use of these tools.

We will track the outcomes of training for **staff/agencies** on key dimensions (e.g., cultural sensitivity, Oregon Parent Management Training, Directive Supervision). We will track number of staff trained and number of trainings and we will interview staff three months post training to assess perceived utility, barriers to implementation, and suggestions for additional trainings. We will also utilize program fidelity instruments attached to the Parent Management Training and Integrated Co-Occurring Treatment for Youth with Substance Abuse and Mental Health Disorders to measure the extent to which applicants implement the programs with fidelity.

2. Infrastructure change. Since the initiative associates outcomes with organizational change, structure and practice of organizational process must be measured directly. We intend to directly assess cross-system (interagency) structures and practices with measures including but not limited to: cross-system training, cooperative assessments, coordinated tracking, and interagency referrals. The use of common forms and shared databases are expected.

3. Cultural sensitivity & family centeredness. The operation and impact of the Family Support Advisory Council and the Cultural and Linguistic Competency workgroup will be documented through task accomplishment and interviews. In the evaluation area the council will help to identify community individuals to participate in interviews with client families. Task accomplishment would therefore include the recruitment of such participants and the actual interviews and other work subsequently performed. Other examples of impact will include council and workgroup's participation in production of educational materials, outreach efforts, and design and vetting of planning protocols. Additional impact areas will include development of shared values training, multilingual availability of materials and services, and assessment of the cultural appropriateness of particular instrumentation. We will also evaluate the extent to which the project strengthens Advocacy Services for Kids and succeeds in offering families greater voice and access in the system-of-care; involves parents and youth in the governance activities of the Integrative Action Team; and the participation of parents in evaluation activities.

4. Monitoring. On-going regular monitoring of process and outcome is essential so that feedback is available for course correction and system planning. Our use of a reporting database will allow us to provide ongoing feedback concerning service utilization, system functioning, and client outcomes so that local stakeholders can detect and rectify problems early. The logic of this approach is well described by Affholter (1994).