

**CHILDREN MENTAL HEALTH INITIATIVE
SM-002-02**

BUILDING ON EACH OTHER'S STRENGTHS

Abstract

Children with serious emotion disturbance (SED) and their family members deserve collaborative care they help plan. The State of Idaho proposes to develop, implement, promote and evaluate an integrated system of care that is community-based and family focused for children with SED. Improving care requires *Building on Each Other's Strengths*. We will combine family members, communities, and public agencies into lasting partnerships for care.

Building on Each Other's Strengths is just beginning. Governor Kempthorne established the Idaho Council on Children's Mental Health (ICCMH) in 2001. The ICCMH is charged with the transformation of separate child serving agencies into a collaborative system of care. Under charter from the ICCMH, local community based councils join with civic leaders in each of the State's seven regions as regional councils. The regional councils provide resources, administrative oversight, and communications link between the ICCMH and local community-based councils. The local councils provide comprehensive assessment, individualized service planning, and review for children with SED at high risk of out-of home placement.

Through technical assistance every partner gains awareness and understanding of their role, pledging their support of the guiding principles and best practices associated with collaborative care. The state-wide Conference, "Children's Mental Health in a System of Care," is the focal point for technical assistance efforts with additional assistance on subject specific areas targeted to identify needs throughout the state. *Building on Each Other's Strengths* bolsters work underway with family advocates bringing children with SED and their family members to the system of care as full partners from the beginning. They become equally valued partners in the development, implementation, and sustainability of the system. Access to care, service planning, and support becomes adaptive to the constantly changing cultural and linguistic diversity becoming increasingly evident in Idaho through inclusion and relevant training.

Building on Each Other's Strengths encourages family members to join in the system of care. Lessons learned during production of the Peabody Award-winning video on adolescent mental health, "Hearts and Minds," form the backdrop for a social marketing campaign targeted toward children with SED and their family members. Partnering with National Technical Assistance in social marketing will ensure a high-impact program across the state.

Information critical for guiding decisions on the effectiveness, efficiency, and priorities for resources is limited and scattered within multiple networks, and across several agencies. *Building on Each Other's Strengths* begins with the merger of children's mental health services information, care management, billing, and payment into a single Family Oriented Community User System (FOCUS). In addition, a state-wide evaluation process, working in tandem with the National Evaluation, will provide outcomes data critical for effective benchmarking and identification of opportunities for continuous quality improvement.

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SECTION A: UNDERSTANDING THE PROJECT

Literature Review: The philosophy and value of children's mental health services provided in the context of individualized, community based, systems of care began with a report from the Joint Commission on the Mental Health of Children (1969). The report found that many children and adolescents with serious emotional disturbance (SED) were not receiving needed services or were inappropriately placed in excessively restrictive settings. They asserted that many children have multiple needs that cross public agency settings, such as child welfare, juvenile justice and special education (Epstein, Kutash, & Duchnowski, 1998). The Commission's observations were supported in *Unclaimed Children* (1982), a landmark study wherein Jane Knitzer documented the desertion of children and adolescents with mental illness by the multitude of government and community agencies that were charged with their care. Knitzer referred to the federal role in children's mental health as the "unfulfilled promise," with no leadership at the federal level (Cole & Poe, 1993; Knitzer, 1982; Stroul & Friedman, 1986).

In 1984, the National Institute of Mental Health (NIMH) launched the Child and Adolescent Service System Program (CASSP). Dr. Ira Lourie, the founding director of CASSP, conceptualized the needs of children and adolescents with SED using a wraparound process, wherein services would be tailored to the specific needs of the youth and family (Burns & Goldman, 1996; Stroul & Friedman, 1986). Throughout the 1980's and with the support of early CASSP efforts (e.g., Alaska Youth Initiative and Kaleidoscope), a shift in philosophy and practice occurred: parents became partners and service arrays developed to reach beyond compartmentalized service delivery to meet the individual needs of children and their families within their own community (Burns & Goldman, 1998). "Systems of Care" emphasized the multiple needs of children with emotional disorders and the importance of developing linkages across child service systems, agencies, and in coordination with families (Stroul & Friedman, 1984). All who worked in a child serving capacity were being asked to look beyond the traditional medical model of treatment (doing things "to" children and families) and develop community based services that would encompass all aspects of their lives (doing things "with" children and families) (Duchnowski, Berg, & Kutash, 1995; Isaacs & Benjamin, 1991; Stroul & Friedman, 1984).

The development of a national family movement in the late 1980's further strengthened the family contribution within a system of care for children with SED. Families were requesting that they become full partners rather than just participants in the care of their children, service delivery systems, and program development (Anderson, 1994; Briggs & Koroloff, 1995; Duchnowski et al., 1995). In 1985, "evidence of the potential contribution that individual family members and family organizations could make to system reform efforts resulted in the addition of a family-related CASSP goal"(Friesen & Huff, 1996). It became apparent that parents and families are essential partners in the provision of children's mental health services across the country. Increasing collaboration, based primarily on child, family, and community strengths in the delivery of services across agencies, natural support networks, and within communities became the goal. Many systems of care offer family-centered services based on child and family strengths, demonstrated by supporting all family members who are involved with the child's care and by the inclusion of family members in all aspects of planning and evaluating the service delivery system (Simpson, et al., 1998). Additionally, acknowledgement of the impact of biological, social, and psychological factors on mental health functioning, and the recognition

that children's mental, behavioral, and emotional health needs are interactive and dynamic rather than linear, was well documented (Friesen & Koroloff, 1990; Simpson, Korloff, Friesen, & Gac, 1998).

Effective service systems must be culturally competent and "have commitment and attention from all levels of the organization" (Isaacs-Shockley, Cross, Bazron, Dennis & Benjamin, 1996) in order to meet the diverse needs of children and families (Anderson, 1994; Isaacs & Benjamin, 1991). In achieving cultural competence, systems of care were challenged to gain a clearer understanding of the importance and influence of culture (Isaacs-Shockley et al, 1996) and develop programs that went beyond focusing solely on race. Service systems had to develop an understanding of the geographic, socio-economic, and total ethnicity of each child and family (Anderson; Briggs & Koroloff, 1995; Isaacs & Benjamin, 1991). More recent projects (e.g. Kmihqitahasultipon Program, South Philadelphia Family Partnership Project, and the K'e Project (Simpson, et.al., 1998) demonstrate the critical tie between culturally relevant services, the family and the well-being of children with SED (Simpson, et al., 1998).

Need for System of Care Reform in this country and specifically in Idaho: There continues to be many challenges across the nation in developing systems of care models. The medical model remains entrenched. Children continue to be placed in settings where families' voices are not heard and their input is not included in treatment planning despite the 2001 report by the Surgeon General that supports infrastructure for cross-system collaboration and development of integrated community networks. The findings in *Unclaimed Children* (Knitzer, 1982) still ring true today in many geographical regions and in communities where agencies deliver services in isolation.

As in many states, Idaho has had multiple child serving agencies addressing the needs of children identified as SED in isolated and uncoordinated ways. Idaho also faces problems common to other states, including stigma concerning mental illness, categorical and fragmented funding and differing agency missions. Unique to Idaho is the isolation and frontier nature of the state, which contributes to specific cultural isolation and inaccessibility of services especially in the rural areas. Early efforts in Idaho's CASSP program provided service provision using a wraparound model. The North Idaho Rural System of Care Project also offered supportive data on systems of care, in a rural region, and demonstrated effectiveness at improving lives of children who met criteria for SED (Lubrecht, 1992). The development and evaluation of a comprehensive state-wide system of care in the proposed *Building on Each Other's Strengths* application will contribute to a structure for quality improvement, systemic responses to gaps at all levels of the service delivery system for children who meet SED criteria, and critical information for policy makers, administrators, direct service providers and families.

Idaho Geography and Demographic Data: Idaho is predominantly Caucasian with 88.0% white, not of Hispanic/Latino origin. The largest minority group is Hispanic/Latino origin (7.9%), followed by American Indian (1.4%), Asian (0.9%), Black or African American (0.4%), Native Hawaiian and other Pacific Islander (0.1%). Population for the state of Idaho is 1,293,953 with 7.5% of the population being children under 5, and 28.5% under 18. There are 17.3% of children living below poverty (Census Bureau, 2000).

Idaho covers a large geographic area (83,557 square miles) from Canada on its northern border to Nevada and Utah in the south. There is a single two-lane road that links the six largest cities in the state from north to south—driving time, eight to ten hours. Two of the 44 counties meet the criteria of Metropolitan Statistical Area (MSA) as defined by the Office of Management and Budget. Of the remaining counties, 26 are classified as rural and 16 are classified as frontier, with frontier areas comprising 59% of the state. These areas extremely isolated and often closed off by winter conditions that last up to six months per year. There are few available social services and many lack basic medical care (Idaho Department of Commerce, 1999).

Description of Children with SED in Idaho:

Prevalence estimate age range: Idaho uses the federal definition pursuant to section 1912(c) of the Public Health Service Act as amended by Public Law 102-321 for purposes of estimating the prevalence of serious emotional disorders and the scope of this public health problem among children and youth. It includes children “From birth up to age 18, who currently, or at any time during the past year, has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV, that resulted in functional impairment that substantially interferes with or limits the child’s role or functioning in family, school, or community activities. A substance abuse disorder or developmental disorder, alone, does not constitute a serious emotional disorder although one or more of these two disorders may co-exist with a serious emotional disorder” (State of Idaho Mental Health Plan, FY 2002). Based on 2000 Census data, the estimated number of children under 18 years with an SED in Idaho is 18,452. This estimate uses a conservative prevalence estimate of 5.0% of Idaho’s children under the age of 18 years. Because of the service system’s limited capacity, the target population must be differentiated from the state’s service goal. The State of Idaho Mental Health Plan’s service goal of 7,381 youth is only 40% of the target population.

Racial and ethnic composition of the children and their families:

Based on Census demographics of minority populations in Idaho, the estimated number of children with SED is 16,238 Caucasian, not of Hispanic origin; 1457 Hispanic/Latino; 258 Native American; 166 Asian; 74 Black/African American; and 18 Native Hawaiian. Not reported in this Census were Central Asian and Middle-Eastern demographics.

The two areas with the largest influx of refugees are the cities of Boise and Twin Falls. Nearly two-thirds of the refugees are located in Boise. The majority, over 60% are from Europe. Over 27% are from South Asia and the remaining split between Latin America, Africa and the Near East. The numbers do not break out by age, so a derived estimate of the number of children with SED from the refugee population is not possible.

Institutional and family settings in which these children are currently located:

- The State Department of Education provides federal and state funding to 115 independent local school districts. Services provided under the Individuals with Disabilities Education Act (IDEA) are provided by the local school districts based upon the child’s need and identified through the Individual Education Plan (IEP). Services are provided according to state and federal IDEA requirements. Education faces some of the same barriers as other child serving systems in rural Idaho, including access to services, service coordination with

other agencies, meeting culturally relevant educational needs of immigrant, ethnic and cultural minorities and parent led case planning.

- The Department of Juvenile Corrections (DJC) provides services to youth committed to its custody for out of home care.
- Forty-four independent county probation departments provide supervision to youth on probation and community supervision after commitment to DJC.
- Private providers of mental health services exist throughout the state. Private provider services range from out patient clinic services and psychosocial rehabilitation services to residential and in-patient care.
- The Department of Health and Welfare (DHW) operates one psychiatric inpatient unit for youth, State Hospital South Adolescent Unit (SHSAU). This unit has the capacity for 16 adolescents (ages 12-17 years). The role of the SHSAU is to provide inpatient stabilization and treatment with stays from 90 to 120 days. Brief, short-term emergency/acute inpatient care must occur at a local level. The State Hospital utilization rate for youth in 2001 was 13/100,000 for children under age 18. The State Hospital South Adolescent Unit admitted 47 patients within the twelve-month period. The average length of stay was 74 days.
- There are approximately 1,100 children in foster care in any single month. This number includes care for both child protection and children's mental health. Foster care placement is on a continuum from foster family home to in-patient psychiatric care.

Current Capacity and Gaps: There are many challenges impacting Idaho's ability to deliver culturally competent system of care services in this rural environment, including:

- Limited access to trained mental health professionals.
- Difficulty in attracting competently trained professionals who understand the concept of "system of care" and are willing to locate in low population areas with high levels of poverty.
- Lack of transportation options to enable access to services.
- Significant gaps such as transportation, employment, housing, medications, and medical care for children and their families who meet poverty guidelines or are without insurance coverage (Idaho State Plan Implementation Report, 2001)
- Lack of sufficient resources for local communities to meet basic community needs.
- Variation in the access of services for children. A comprehensive system of care is not available in any part of the state. Comparable services where families could expect the same service in two different areas of the state are unpredictable, including critical services such as treatment foster homes and respite care.
- Insufficient support services for families and lack of organizational supports for natural helping networks.
- Lack of training, awareness, and understanding in the local communities about how to assist in responding to children with cross system needs.
- In a resource poor state, reluctance of agencies to move toward combining efforts and utilizing assets because of already high demands on their systems.
- The CMH response system tends to be ethnocentric which results in a general lack of development of services that are relevant or sensitive to any group other than the dominant culture.
- The services for highly rural or ethnic minorities are not relevant to needs, strengths and contexts of children and their families.

- Lack of access to services/supports is particularly acute among Idaho’s minority groups because of a shortage of providers who offer culturally and language appropriate services.

A needs assessment of Idaho’s response to CMH issues identified steps for developing a comprehensive, collaborative system of care (Davis & Lourie, 1999) and has become the guiding document to develop a system of care for children with SED and their families in Idaho. This needs assessment specifically identified the following five areas that Idaho must address:

- Too many resources being used to purchase expensive, institutionally-based care for relatively small numbers of children, while too few resources are being used to purchase community based care.
- Title IV-E and Medicaid Rehabilitation Option are underutilized in Idaho. Dollars could be cleared for reinvestment in the system of care through increased federal claims for services.
- Data collected are minimal and do not evenly or adequately describe services purchased or children served.
- There are few utilization management or other quality improvement practices in place.
- Agencies in the best position to address the needs of children with SED and their families through integration of their efforts have not worked together consistently or effectively.

Benefits from Other Initiatives: Idaho has a myriad of programs that individually address differing mental health needs. The proposed project will be coordinated with the following programs to integrate these efforts into one system of care for children with SED and their families:

- Idaho State University Telehealth Grant has adopted “Building on Each Other’s Strengths” as a pilot. They will provide technology to support workforce development and improved rural access to children’s mental health services.
- DHW has contracted with the Idaho Federation of Families for Children’s Mental Health, Inc. (IFFCMH) to provide support, advocacy and education to the parents and families of children and youth with mental, behavioral and emotional disorders and the professionals that work with them. IFFCMH currently has support groups for parents, sibling support groups for brothers and sisters of children with SED, and offers ongoing training in areas such as advocacy, systems of care, signs, symptoms and treatment of mental health disorders and parent/professional collaboration. IFFCMH is also in the process of completing a needs assessment related to distance learning across the state in order to better serve the needs of families and professionals in rural areas of the state.
- The Idaho Council on Children’s Mental Health (ICCMH) established an early identification workgroup consisting of child care providers, pediatricians, parent representatives, infant toddler staff and interagency coordinating council members to identify an age appropriate assessment tool and develop assessment methods that can aid in the accurate identification of young children with developing SED symptoms. In addition, this workgroup should identify appropriate treatment methods and additional programming options for this age group.
- DHW has two flexible funds available to families with SED children: MASH (Monetary Assistance to Support Homes) and Emergency Assistance (TANF) funds. Flexible funding is a key system of care resource.

- Community Resources for Families is a collaboration between DHW and individual school districts. One program goal of this school-based service is early identification and prevention services for Children with SED.
- Idaho's Community Integration Initiative and grant (in response to the Olmstead Act) incorporates Children's Mental Health as a target population. Objectives of this initiative include: increasing access in all forms; increasing availability and adequacy of services; increasing value of care; increasing quality of the system. An anti-stigma campaign related to all disabilities will be conducted.
- Red Flags is a TANF-funded early identification program that educates parents, teachers, and community members on the signs and symptoms of childhood mental illness.
- Idaho's six Indian Tribes and DHW meet jointly on state/tribal issues related to TANF and Indian child welfare. These committees will provide consultation for this initiative.
- Medicaid Mental Health Rehabilitation Option has a large pool of public and private sector providers who provide home, school and community-based services to children with SED. This initiative will expand this provider network. DHW contracts with these same providers for the same services to non-Medicaid eligible children.
- DHW is developing university/agency partnerships. These partnerships will support training, research and workforce development for this initiative.
- Idaho's First Lady is supporting an initiative to conduct a needs assessment and recommendations for the development of respite care. This will form the basis for the development of respite care for children with SED.
- Early Childhood Clearinghouse and Idaho Careline are web-based and toll-free information and referral services, respectively. They will be instrumental in supporting the social marketing activities of this initiative.
- The Idaho Kinship Care Initiative (1997-2000) was an agency/university partnership training initiative designed to enhance the knowledge and skills of DHW staff, partners and Tribal child welfare agencies in conducting family group decision-making and utilizing relative and kin placements. Such strategies are integral to culturally competent practice. Videos and other training materials are available from this initiative.
- Idaho's Governor has a "Generation of the Child" initiative, which challenges state agencies and local communities to realign as a means of improving access to services, increasing cooperation, and seeking coordination in order to maximize the resources we have.

Goals of the Cooperative Agreement Program: Through the implementation strategies outlined in Section B of this *Building on Each Other's Strengths* application, we envision that the following will be achieved:

Program Goal 1: Develop systems of care for children with serious emotional disturbance and their families.

We envision a parent driven, family focused, collaborative community care system for children with mental, emotional and behavioral disorders and their families, where parents are valued as being knowledgeable and are comfortable about accessing a full array of services in their own community. The array of services are individualized, coordinated and integrated to meet the family's cultural/linguistic and ethnic needs. No matter which point of agency access the parents enter, they are involved in the assessment, planning, implementation and evaluation of the treatment goals necessary to support their child and family.

Program Goal 2: Provide a broad array of mental health and other related services, treatments, and supports to children with SED and their families.

We envision the most appropriate services are available at the local level to meet the needs of children with SED and their families.

Program Goal 3: Evaluate the effectiveness of the system of care and its component services.

We envision parents, youth, service providers, and administrators all understand and value the importance of using program effectiveness data for making decisions leading to systems improvements.

Program Goal 4: Involve families in the development of the system and the services, and in the care of their own children.

We envision families, youth, system providers, and policy makers working together in teams with a focus on doing - whatever it takes - to continuously update and improve the system of care to meet the needs of children with SED and their families. Families are supported, encouraged, and acknowledged for their expertise and experience with their child and that they are respected for doing the best that they can in the efforts that they make with their children.

Program Goal 5: Use cultural competence approaches for serving children and their families from minority racial and ethnic populations in the community.

We envision that children identified as having SED and their families, throughout the state, will have equal access to high quality services delivered in an environment that respects and honors diverse cultural values and language differences.

SECTION B: IMPLEMENTATION PLAN

“Building on Each Other’s Strengths: Idaho’s Children’s Mental Health Initiative” directly relates to the Children’s Mental Health Initiative program goals. In the following section, we will describe how we will develop the program goals in the State of Idaho.

This application was written based upon recommendations of the Needs Assessment of Idaho’s Children with Serious Emotional Disturbance and Their Families (Lourie & Davis 1999). That document identified recommendations for developing a system of care relevant to Idaho. In response, three time-limited demonstration sites were established to determine community readiness for the systems of care model. Each demonstration site developed mechanisms to provide collaborative, coordinated, comprehensive, community-based service planning for children with SED and their families based on full family participation, family strengths and needs aligned with community resources. The two year study is devoted to establishing the councils, staffing cases, gathering data, identifying measurement tools, outcomes, targets and essential information for the development of a more comprehensive plan. This study ends June 2002, with the evaluation report due in October 2002. The results will help with formation of councils statewide.

Idaho currently has in place the initial organizational structure to develop a system of care for children with SED and their families (see appendix 6). The Governor established the Idaho

Council on Children's Mental Health (ICCMH) by Executive Order 2001-15 (see appendix 1). Chaired by the Lieutenant Governor, members include the Executive Director of the IFFCMH for Children's Mental Health, a child psychiatry practitioner, a member of the State Mental Health Planning Council, a representative for the County Commissioners, the agency directors for Health and Welfare (DHW), State Department of Education (SDE), Department of Juvenile Corrections (DJC), a representative of the Idaho Supreme Court, a member of the Idaho Legislature, and a representative from the Office of the Governor.

The ICCMH is charged with the development of Regional Councils. The Regional Councils serve as the communication link between ICCMH and Local Councils, the focal point for the collection of Local Council data, the fiscal advisory group for Local Council funding, and policy advisory group to the ICCMH. Regional Council membership includes a parent of a child with SED or a parent advocate, Regional Mental Health Advisory Board Member, and representation from DHW, DJC and SDE. The ICCMH also ensures the development of Local Councils. The local councils collaborate in the service planning and monitoring of children with SED and their families, identify and develop community based supports, and identify resources and services gaps. Local Council membership includes parents of children with SED or a parent advocate, service providers, community leaders, county juvenile probation, and representatives from DHW, DJC and local school districts. The ICCMH, the Regional Councils, and Local Councils provide the forum at all levels of the system for family member involvement, interagency collaboration, service integration, wraparound process, case review, access, fiscal sustainability and community leader support. *Building on Each Other's Strengths* will build upon the initial efforts of the ICCMH to build Regional and Local Councils

The infrastructure necessary to provide the treatment and support needed for children with SED and their families will be developed through the interaction of agency partners on the councils, ICCMH activities, and individual efforts. ICCMH will recommend best practice standards for council services. Funding for ICCMH activities is budgeted for consultation, technical assistance and research on best practice standards. Technical assistance on system of care development and services is also available to the state through the federal review of the State Mental Health Block Grant in 2001.

The ICCMH endorsed the application for *Building on Each Other's Strengths*. Members unanimously accept their role as the governance body for *Building on Each Other's Strengths*, including oversight and implementation.

DHW serves as the lead agency for current efforts and will continue as the administrative team for this *Building on Each Other's Strengths* application. Initial data gathering structures are provided through the DHW's Information Management Systems. These systems include the common client directory, the Family Oriented Community User System (FOCUS), the Service Evaluation and Family Satisfaction survey database system, and the Medicaid client database. DHW is currently developing plans to merge into a single client information system while complying with the Health Insurance Portability and Accountability Act (HIPAA). DJC and the State Department of Education maintain their own information systems. IFFCMH is developing a database system to track consumer satisfaction and needs as reported by families across the

state. The councils will be required to report on the data needed for the evaluation. Information system enhancements will be developed for data and evaluation requirements.

Each regional and local council will provide points of contact within their geographic area. It is not the intent to set up a separate office for each council but to use the facilities of one of the member agencies. A description of how to contact an area council will be published through brochures and other social marketing techniques.

The Needs Assessment document describes two primary goals: “First, a floor of service capacity must be solidly established across all regions for the most basic set of community based services necessary to treat emotional disturbances and limit the utilization of more expensive, intensive services to those children for whom those intensive services are the best and necessary choice. Second, the system as a whole needs to expand the availability and quality of child mental health expertise in all regions” (Lourie & Davis, 1999). A third important goal is increasing access to community based mental health services.

The ICCMH has established the following definitions for core children’s mental health services to be provided statewide. These definitions and the measures will be utilized for the system of care.

CMH SERVICE DEFINITIONS & MEASURES	
DEFINITIONS	MEASURES
<p>ASSESSMENT: Assessment is the use of the clinical interview, psychometric tools as needed, community, and family as well as other pertinent information to address safety issues, family’s /child’s concerns, strengths, and resources to determine the child’s mental health service needs.</p>	<p>MEASURES: Number of children receiving assessments per region Referral source Number of days between referral, application and assessment per region</p>
<p>CASE MANAGEMENT SERVICES: A process for linking and coordinating segments of a service delivery system, within a single agency or involving several providers, to ensure the most comprehensive program for meeting an individual’s need for care. This does not include Regional Mental Health Authority (RMHA) activities that primarily include administrative functions such as authorizing services, contracting with providers, managing service delivery for quality and outcomes.</p>	<p>MEASURES:</p> <ul style="list-style-type: none"> • Number of children/families receiving case management services per region • Duration of case management services per region
<p>THERAPEUTIC FOSTER CARE: A service that provides therapeutic intervention for children with mental health needs within the private homes of trained families. The approach combines the influence of family-based care with specialized behavioral interventions with clinical support that creates a therapeutic environment in the context of a family home and incorporates the biological family to the greatest extent possible.</p>	<p>MEASURES: Number of children served per region Number of therapeutic foster homes in each region Number of beds available in each region Number of dollars spent on this service</p>

CMH SERVICE DEFINITIONS & MEASURES	
DEFINITIONS	MEASURES
<p>CRISIS RESPONSE SERVICE SYSTEM: Crisis response services are an individualized response to assure safety when a child is believed to be in imminent danger of causing life-threatening harm to self or someone else due to a severe emotional disturbance. Crisis services require access to services, 24 hours per day, 7 days per week to assess risk and place in alternate care, if necessary, to assure safety for the child. Each protocol will be in conformity with the established standards of the statewide task force.</p>	<p>MEASURES Number of presenting issues per region Local protocols are in place – contracts /agreement between agencies identifying roles</p>
<p>DAY TREATMENT: Collaborative structured intensive treatment in a school or other educational setting aimed primarily at emotional and behavioral interventions resulting in decreased psychiatric symptoms and increased level of functioning. It is a continuum of services that is the least inclusive to most inclusive up to full school hours. It may include services such as companions/tutors to receiving services in an off site school setting.</p>	<p>MEASURES:</p> <ul style="list-style-type: none"> • Number of children served in day treatment per region. • Number of contracts/ collaborative agreements for day treatment programming and school districts served under those agreements per region
<p>FAMILY SUPPORT SERVICES: Assistance provided to families to manage the extra stresses that accompany caring for a child with mental health needs. The main goal of family support services is to strengthen adults in their roles as parents through the provision of resources for transportation, family preservation services, emergency assistance funds, training or education, etc.</p>	<p>MEASURES:</p> <ul style="list-style-type: none"> • Number of families per region • Number of contracts / collaborative agreements per region • Number of dollars spent
<p>INPATIENT SERVICES: Services provided within the context of a psychiatric hospital setting. This level of care provides a high level of psychiatric and medical care and is utilized in times of potentially dangerous or high-risk situations.</p>	<p>MEASURES: Number of dollars spent on services Number of children receiving inpatient services per region Length of stay</p>
<p>OUTPATIENT TREATMENT: Outpatient treatment is the least restrictive component within the continuum of care. The child and/or family receive treatment and or medication monitoring. These interventions are designed to decrease distress, psychological symptoms, and maladaptive behavior or to improve adaptive and pro-social functioning.</p>	<p>MEASURES: Number of children served (Medicaid and non-Medicaid) per region Number of dollars spent providing outpatient treatment (Medicaid and non-Medicaid)</p>
<p>RESIDENTIAL TREATMENT CENTERS: Children’s group homes and treatment facilities that provide 24 hour care in a licensed highly structured setting delivering comprehensive therapeutic interventions.</p>	<p>MEASURES:</p> <ul style="list-style-type: none"> • Number of children served per region • Number of residential treatment centers per region • Number of beds available per region • Number of children placed in state

CMH SERVICE DEFINITIONS & MEASURES	
DEFINITIONS	MEASURES
	<ul style="list-style-type: none"> • Number of children placed out of state • Number of days waiting in alternative care while awaiting placement in a facility. • Length of stay • Number of dollars spent on this service
RESPITE CARE SERVICES: Respite services consist of time limited family support services in which an alternate care provider provides supervision and care for a child with mental health needs, either within the family home, residential or group home, or within a licensed foster home. Respite care can be provided both as planned and crisis service.	MEASURES: Number of children receiving respite care services per region Number of planned respite services Number of crisis respite services Number of dollars spent on respite care Length of stay in respite

Transition planning is currently agency specific and non-standard because of the different agency services, eligibility and target population. The ICCMH will set statewide standards for councils regarding the transition of youth from children’s services to adult services. The expected standard for transition planning is that it will be initiated during their 14th year of age.

Currently each agency provides an agency specific assessment, treatment plan and services. Once established, Local Councils along with parents will provide the forum for building a comprehensive, coordinated community-based assessment for children with SED based on family strengths and needs. Using the child and family’s goals and the comprehensive assessment as a guide, individualized service plans are developed during local council staffings in partnership with the parents. Every case staffed by the councils will result in an individualized service plan, except when the parents withdraw from services prior to the development of the service plan.

Local councils will identify a base line of services as identified by the CMH Service Definitions and Measures during their first year of operation. They will also identify service needs and gaps. Regional councils will compile the local councils’ information to develop regional profiles of service needs, priorities, and gaps. The ICCMH will develop a statewide profile of service needs, priorities and gaps and will provide a community report card to the public. The ICCMH will also be reporting annually to the Governor on the state of children’s mental health services. The community report cards, lessons learned from ongoing projects, findings shared through the *Building on Each Other’s Strengths* “learning community,” and best practice research will provide policy makers the information essential in recommending systemic changes and establishing priorities.

Once the baselines are established, the regional and local councils will establish targets for developing or enhancing services. Strategies will then be developed and implemented to reach those targets. An example is the enhancement of therapeutic foster care. This service exists in areas of the state, but not in sufficient numbers or in every community. Collaborative strategies could be developed at the regional council level to team with child welfare in foster care recruitment and training efforts resulting in more trained therapeutic foster homes. Similar strategies could be used to enhance day treatment programming through collaborative efforts and funding with councils and school districts. Local and regional council membership will also reflect the racial and ethnic diversity of the community. This will encourage consideration of alternative healing practices and encourage minority access to services.

Optional services: Optional services will be developed in response to the specific individualized needs of the children and families. Training will play a major role in the development of the system of care. Initial training will focus on defining system of care, family advocacy and the need for family involvement at all levels within the system, parent/professional collaboration, interagency collaboration, system integration, best practice standards on services, cultural competency, and individualized service planning and intervention strategies. These trainings will define a method for screening and comprehensive assessment to determine a child's eligibility for council services. Parents have expressed a strong interest in training on child specific interventions based upon their child's needs. Curriculum has been developed by IFFCMH on many of the topics listed above and further curriculum development is in process. Training will be made available to parents and professionals alike by IFFCMH, in conjunction with partner agencies and universities.

Non-mental health services: Non-mental health services will be provided through the system of care. The State Department of Education is a member of ICCMH. Local school districts are becoming members of regional and local councils. This links educational needs and services into a system of care. Non-mental health services in the community support families through respite care, substance abuse prevention and treatment services, the Children's Health Insurance Program (CHIP), and vocational rehabilitation services. Many of the non-mental health service programs are administered in DHW. An intra-agency workgroup has been established to identify and eliminate barriers across programs.

Protection and advocacy will be available through several avenues. DHW partners and contracts with the IFFCMH for advocacy, support and educational services for families of children with SED and the staff who work with these children, youth, and families. Idaho Parent's Unlimited is Idaho's Parent Information and Resource Center and provides information primarily in the area of educational services. Co-Ad is the state's protection and advocacy organization for persons with disabilities.

DHW is the agency that facilitates and provides services under Title XIX, Title IV-A, Title IV-B, Title IV-E of the Social Security Act, and EPSDT. The Idaho State Department of Education and local school districts provide IDEA services. See Appendix No. 1 for a copy of the state level memorandum for school services.

Individualized Service Plans: Local councils will be providing the individualized service plans that outline clinical interventions and other identified needs. These interventions will be developed with the family during a staffing with council members, the family, and any other participants that the family would like to invite. The staffing and information about the child and family will be confidential. Guidelines for staffing procedures, parental consent and confidentiality will be addressed by the ICCMH. Local council members will have the ability to provide services from their agency/organization during treatment planning and service delivery. The goal is “to resource the plan, not plan the resources” around the child and family. This goal will result in a coordinated, integrated, comprehensive individualized service plan. The success of the goal to resource the plan was reported by one of the Idaho demonstration sites as instrumental in moving to individualized service plans.

Clinical interventions: Clinical interventions will focus on the core of community based services as defined previously. These services will be developed with family involvement in the planning, delivery and monitoring of services, combined with interagency collaboration, integration and coordination of these services. Assessments will build on family strengths and identify the most appropriate treatment based upon those strengths, the diagnosis of the child, needs of the child and family, and relevant cultural differences of the child and family.

Clinical staff of DHW are masters degree social workers. Other members of local councils will include a parent advocate, para-professionals and other degreed personnel. Recurring training of staff in this proposal will focus on cultural competency, family inclusion at all levels of the system, system of care philosophy, and best practices for clinical interventions. The technical assistance aspect of this initiative will be utilized to develop specific technical assistance and training in these areas.

Case management: It is anticipated that 100% of the families served by local councils will have case management services either through the family as a case manager or one of the agencies involved. Families as case managers is a new concept but feasible within Idaho. Families as case managers strengthen their role and involvement in case planning, service delivery and monitoring of services. Otherwise, the agency most directly involved with the family will provide case management. IFFCMH has the ability to provide initial and ongoing training and support to families who choose to be their child and family’s own case manager. Local councils will have the option of utilizing available funding for contracted case management services. Case management services will be designed around coordinating, evaluating, monitoring, and adjusting the individualized plan. The case manager will work in conjunction with the family, child, service providers, and local councils.

The families and local councils will develop the individualized service plans based upon an assessment of strengths and needs, with respect given to cultural or ethnic diversity as identified by the parent and child. These service plans will focus on treatment interventions, family support and other services targeted toward the needs identified in the assessment. The process of local council staffing will ensure parent and child inclusion and coordination of interagency services such as, special education and related services, family support services, child welfare and substance abuse services. The same section of DHW as Children’s Mental Health services provides child welfare and substance abuse services.

The individualized service plans will identify specific tasks and activities to be accomplished, the responsible party or agency, date for reassessment, identification of a case manager, and signature lines for all participants. Reassessment and revision of the service plans are essential to the ongoing evaluation of effective treatment interventions. Regular intervals for reassessment and feedback on progress will be the standard practice.

Family involvement: Idaho has an active statewide parent advocacy and support organization, the Idaho Federation of Families for Children’s Mental Health (IFFCMH). The Executive Director of IFFCMH is a member of the ICCMH, the governance body for this initiative. She is also a member of the Children’s Mental Health Subcommittee, a policy development committee of the DHW, the Special Education Advisory Board, and is on the Executive Council of the Idaho State Planning Council on Mental Health. The State Planning Council on Mental Health also includes parent representatives from all seven regions of the state. Regional and local councils will include a parent representative or parent advocate on each council. This initiative proposal includes one full time equivalent position, most likely a contracted position, to serve as the key family contact for the system of care. The position duties and responsibilities will be consistent with the federal requirements. The DHW has a policy to reimburse parents for their costs associated with participation on advisory boards or councils and a stipend for their participation. DHW contracts for statewide parent support and advocacy. The funding for this contract is in the base budget of DHW.

Youth Involvement: Youth involvement will be developed under *Building on Each Other’s Strengths*. The proposal will include funding for a youth coordinator position, most likely a contracted position in conjunction with the key family contact and IFFCMH. The IFFCMH and the State Planning Council on Mental Health both believe that youth participation is essential, thus both have actively sought youth involvement at the policy level. IFFCMH is also working to develop a youth alliance to meet the needs of youth and young adults with mental, behavioral and emotional disorders. Part of this proposal will encourage the development of this youth alliance to bring more young people to the table as members at the state, regional, and local levels.

Building on Each Other’s Strengths, through the use of the youth coordinator, will recruit youth representatives to serve on the ICCMH, Regional and Local Councils. The youth coordinator will work with the technical assistance and communication manager to involve youth representatives in planning in the development of the social marketing and training plans.

Cultural Competence: Hispanic representatives will participate at all levels. Current relationships with the Idaho Hispanic Commission and the Idaho Migrant Council will facilitate council membership. There are six tribes within Idaho and *Building on Each Other’s Strengths* will use existing local and state relationships to assure tribal involvement at all levels of the system.

DHW in conjunction with the six Idaho Tribes will feature cultural issues related to children’s mental health at scheduled Indian Child Welfare Conferences. In addition, DHW has a

contractor working with the six Idaho tribes to produce a short video on the unique culture and history of each tribe. This video will be used for cultural competency training of staff.

Training on cultural competency will be reoccurring using nationally recognized cultural experts. Local representatives from minority communities will also be used as trainers.

Select social marketing materials concerning *Building on Each Other's Strengths* will be produced in culturally and linguistically appropriate format for the target audience. Interpreters and bilingual individuals will be utilized when the families' primary language is something other than English.

Training and Technical Assistance: As noted in *Promising Practices: Training Strategies for Serving Children with Serious Emotional Disturbance and their Families in a System of Care* (1998), building a system of care "will require a transformation in both pre-service and in-service training. There is a need for all those involved in training to develop a clear understanding of the necessary competencies based on a set of broad principles and knowledge both of what works to improve outcomes, and what appear to be promising practices even though not yet supported by empirical findings. There also is a need to develop training systems that incorporate effective training methods and assure that those in practice are competent in using the knowledge, skills, values and attitudes they possess" (Meyers, Kaufman, & Goldman, 1998).

Training and technical assistance will be a major component of *Building on Each Other's Strengths*. The Technical Assistance Coordinator will develop and implement a training plan. Key components of this plan will include cultural competency and systems of care training for all levels of the system, parent led training, collaboration training, and full participation in the national "learning community" training initiative.

There are efforts currently underway to form a workforce development and training workgroup. The purpose of this workgroup will be to determine how agency/university/family partnerships can facilitate pre and in-service training on systems of care principles and competencies, best practice standards and evaluation. The outcome of this partnership will be the development of system of care expertise in the workforce and at the university level. The technical assistance coordinator will play a role in this ongoing work group

Social Marketing: Idaho has a shortage of appropriate providers to serve children with SED, particularly in rural areas. This indicates a need for resource development, additional training, exploration of funding options, and improved retention strategies to retain a quality work force. To effectively address these issues, *Building on Each Other's Strengths* will need high quality educational and media materials that target a range of audiences, including the general public, providers and potential providers, and legislators and administrators. Children with SED and their families also need clear and understandable information about their community options, as well as education about mental illness.

Lack of access to services and supports is particularly acute among Idaho's minority groups because of a shortage of providers who can offer culturally and language-appropriate services.

All levels of care need to be addressed and separated from the “one-package deal,” which may force payment for unused services.

In 2000, the ICCMH published the first ever “Parent’s Guide to Children’s Mental Health Services” in both English and Spanish. The next updated version will also be published in both languages. Some other valuable social marketing materials were developed as a result of an extensive anti-stigma initiative by the DHW and the State Mental Health Planning Council. This initiative was conducted in conjunction with Idaho's First Lady, who provided personal testimony and served as a spokesperson. Materials produced from this anti-stigma initiative include:

- “Hearts and Minds” – This video, in which teens with mental illness tell their stories, won a Peabody Award. It was also distributed to high schools throughout Idaho and has been shown during prime time on PBS twice during the last year.
- A 20-minute video for use in high school health classes. This video augments materials from the Red Flags Training Program, an early-identification training program for parents and teachers, which is used in Idaho.
- A web site that contains teacher's guide materials.
- A 7-minute video designed as a public speaking tool.
- Idaho Public Television produced an hour long documentary on adult mental illness, “In Our Own Voice”.
- Three public service announcements, featuring the First Lady.
- Careline, a statewide DHW information and referral service, has its number printed on all materials of this initiative.

The anti-stigma initiative was developed as a public participation campaign. Extensive public input through surveys and focus groups helped inform the project. This was Idaho's first attempt at such an initiative. Both the lessons learned and the products created from the anti-stigma initiative will be incorporated into the social marketing campaign associated with *Building on Each Other's Strengths*.

For *Building on Each Other's Strengths*, the next developmental steps or purposes of a statewide social marketing campaign are to increase access to services, increase community-based support, and to increase cultural appropriateness. We will also want to maintain the momentum gained in reducing stigma. The opportunity to receive the technical assistance in social marketing associated with this grant is very timely.

Idaho State University Institute of Rural Studies was recently awarded a national Telehealth Grant to improve access to behavioral health services. ISU has adopted *Building on Each Other's Strengths* as a pilot. They will provide the *Building on Each Other's Strengths* with videoconference technology to support workforce development activities. We will also explore the feasibility of using this technology to deliver some children’s mental health services in rural areas.

We intend to hire a Communications Manager to spearhead the development of a social marketing plan. This person will also coordinate the campaign and develop a contract for the services of a communications and media agency. The Communications Manager will work

closely with the Youth Coordinator, ICCMH, Key Family Contacts, cultural consultants, IFFCMH, regional and local councils and other stakeholders to develop the marketing messages and assure the messages are congruent with the system of care philosophy, are culturally sensitive and tailored to the intended audiences. All materials will list the toll-free, state run health care information line, the Idaho Care Line, as a contact.

Capacity and Quality: *Building on Each Other's Strengths* augments increased capacity and quality of services in the system of care as being directly related to the introduction of a collaborative child serving philosophy statewide. An integrated system that is family focused and parent driven will increase capacity because it will remove single point of access. Collaboration between the agencies that serve children will also reduce the duplication of services, which often creates situations that are confusing for the child and family. Crucial resources are often wasted in providing services that are ineffective or that do not meet the needs of children with SED and their families. This is an issue of both quality and capacity. The implementation of state-of-the-art community-based services will allow Idaho to reduce the use of those precious resources from ineffective services and utilize innovative, evidence-based services. Additionally, by removing the barriers created by a system that silos services and programs in the agencies that provide them, access to a comprehensive array of services between agencies will appear seamless to the children and families that so desperately need them.

While it is difficult to predict the number of children and families that will be served, data collected through DHW's service system, and the experience and knowledge from the two-year demonstration projects will be used to estimate the numbers. According to national data, it is estimated that approximately 5% of the children and youth under 18 years of age have a SED. The 1999 Needs Assessment document estimated that 40% of the population of children with SED would need publicly funded services (Davis & Lourie). Using the 2000 census data, we can roughly estimate that 7,300 children in Idaho identified as having SED will need publicly funded services. Many of these children are served appropriately through existing services. However, many will require a coordinated approach of service delivery to best meet their needs. *Building on Each Other's Strengths* expects to serve increasing numbers of children and their families with a comprehensive array of individualized services through the evolution of a system of care. A conservative estimate of the children that will be served in year two is approximately 5% of the 7,300 children, or 365 individual children and families needing publicly funded services. It is expected that this number would increase annually by 20% or 91 children. Given the estimated numbers served in year two, it is expected that by year six the system of care would serve 657 children and their families.

Through collaborative efforts, the system of care will provide a comprehensive array of services to children and families of children with a SED. The following table estimates the number of children to be served through the comprehensive array of core mental health and support services. It became clear in the production of the estimates that Idaho's children's mental health system has a number of critical elements that must be addressed in order for accurate reporting of the core services. For example, day treatment has a common definition, but the operational definition and how those services are conducted do not allow for valid comparison between programs. Some day treatment programs report serving 400 children and some report serving 20 children. With day treatment, and all of the core services, it will be necessary to establish criteria

for defining the programs that allows for cross program comparison. Currently we do not have hard data to assess the number of key services provided by the collaborative group of providers, but we are in the process of gathering that data through the regional and local councils. We do, however, anticipate that we will continue to build our existing level of core services to meet the needs and requests by families and providers.

Core Service (Key Service Areas)	Estimated Number of Youth Served in Year 2 of Grant Cycle	Estimated Number of Youth Served through Year 6 of Grant Cycle
Assessment/Evaluation	365	657
Crisis Response	95	171
Case Management	365	657
Therapeutic Foster Care	29	52
Day Treatment	80	144
Family Support Services	32	57
Inpatient Services	4	7
Residential Treatment Services	12	22
Respite Care Services	69	124
Outpatient Services [Intensive Home Based]	156	280
[Other]	127	228
Total Estimated Children Served	365	657

Eligibility Criteria: The eligibility criteria is defined as a child under the age of 18 or 21, if served by an Individualized Education Plan (IEP), presenting with a diagnosable condition as determined by the DSM-IV or DSM-IV-TR. Additionally, the child must present with a condition that causes substantial functional impairment in the home, community or school setting. The Child and Adolescent Functional Assessment Scale (CAFAS) will measure functional impairment. A score of 80 or above has been set as the measurement to determine functional impairment. This 80 or above score will be evaluated yearly to determine if it is the correct score for the target population and system resources.

In the continuing development of the system of care, enrollment into services or access to the services provided can and will be made through not a single door, but multiple doors that families can easily identify and access. Recognizing that it is also necessary to have a defined pathway or identified point of access, each partner agency/organization involved in the local council will identify how their agency/organization will present referrals. This will include a defined structure for the identification of children needing the services and how those children can best be identified. Families will be partners in defining the structures that will be used in identifying children and youth who qualify for services.

Individuals contributing to the development of this application include:

- Olga Kramar, Family Member, Parent of a child with SED; research, service planning, and project plan design
- Claire Kiener, MSW, Executive Director, IFFCMH; proposal edit and critical review.
- Kathleen Berg, M.Ed. with emphasis in family life, Parent Advocate and systems of care consultant; editing and assuring parent perspective.
- Don Pena, Executive Director Hispanic Commission; concept input and review and support letters.
- Josephine Halfhide, Indian Child Welfare Program Specialist; coordinate with tribes, concept input and review and support letters.
- Chuck Halligan, MBA, Child and Family Services Bureau Chief, DHW; application drafting, review, edit, coordination, program conceptualization.
- Decker Sanders, MPA Senior Project Manager, Children’s Mental Health Project, DHW; application drafting, review, edit, coordination, program conceptualization.
- Ross Edmunds, MSW, Children and Family Services Program Specialist, DHW; research, application drafting, program conceptualization.
- Mardell Nelson, MSW, Administrative Program Specialist, Division of Family and Community Services, DHW; application drafting, work force development section, edit and coordination.
- Patty Gregory, MSW, Director, Idaho Child Welfare Research & Training Center, Eastern Washington University (EWU); literature research, application coordination, review.
- Richard Phillips, PhD., Professor, EWU, Department of Education; evaluation research and design.
- Sandra Altshuler, PhD., Professor, EWU, School of Social Work; application drafting, edit, and review.
- Ruth Galm, Director of Grants and Contracts, EWU; grant vision input, budget consultation.
- Diane Schmitz, Office of Grants and Contracts, EWU; editing, grant vision input, budget consultation.

Discuss the extent to which non-federal match dollars demonstrate interagency collaboration from child serving agencies: DHW contains the primary child-serving functions for children’s mental health within the Division of Family and Community Services, Children’s and Family Services Bureau. State general fund dollars appropriated for children’s mental health services provide the non-federal match required for the application. In-kind match will be provided over the life of this grant by non-DHW agencies using non-federally matched state funds. During the first year a method will be developed to track, document and audit in-kind match. The in-kind match will be in the form of staff time for council activities (salaries), meeting space and purchase of services for children and families served through the councils.

Sustainability Strategies: By the end of the first year, partner agencies and councils work with the project in developing a protocol to accurately record and track “in-kind” contributions to *Building on Each Other’s Strengths*. The amount of “in-kind” match is expected to increase beginning in year two and continue throughout the project life cycle as additional communities develop and establish local councils serving children with SED and their families. Tracking the “in-kind” match, by the amount and source, within each council will show the commitment to the system of care at all levels while leveraging the non-federal match in the latter years of the project. The strategy for family inclusion in the system of care will be to continue providing

financial supports to families who are participating in council meetings and specialized work groups. In addition, the state will maintain financial support for a statewide family advocacy and support organization.

SECTION C: PROJECT MANAGEMENT

Applicant Organization: DHW is an executive agency under the leadership of Idaho Governor Dirk Kempthorne. The Director, Karl Kurtz, oversees all Department operations and is advised by a seven-member State Board of Health and Welfare. Applicant Organization Chart (See Appendix 6)

The state is divided into seven geographic regions. Each region has a director, with staff spread throughout to provide services at a grass roots level. Our services are organized under seven divisions. Each division provides services or partners with other agencies and groups to provide these services to our communities.

The Division of Welfare administers the Self-Reliance Program. This program includes eligibility-based public assistance; related employment, training and support services; child support services; and community programs.

The Division of Medicaid designs, implements, and reviews state-funded medical assistance services for people at risk due to low income or other factors, such as youth, old age, pregnancy, or disability, pursuant to state and federal Medicaid requirements. The Division provides a complete program of medical and dental services to eligible recipients throughout Idaho. The Division also licenses health facilities, administers the Children's Health Insurance Program (CHIP), and participates in the federal Medicare program.

The Division of Family and Community Services (FACS) directs State social services programs, including those for child protection, adoptions, foster care, children's mental health, adult mental health, developmental disabilities, early intervention and screening for infants and toddlers, and substance abuse prevention and treatment. These programs are integrated to provide services for children and families that focus on the entire family unit, building on family strengths while supporting and empowering families to be self-reliant. Under FACS, we operate three special hospitals throughout the state, providing services to people with mental illness and/or developmental disabilities.

The Division of Health includes Physical Health Services, Emergency Medical Services, and Laboratory Services.

The Division of Management Services provides administrative services to support DHW's mission. Through cooperation with other divisions, it manages budget cash flow, oversees accounting and reporting, performs internal reviews, manages physical assets, and processes all personnel actions.

The Division of Human Resources – in collaboration with the Idaho Division of Human Resources, the Idaho Attorney General's Office and other state and community partners –

provides supportive, practical, consistent and creative human resource services to attract, retain, and develop DHW's human resources.

The Information and Technology Services Division (ITSD) provides support to DHW's programs to ensure effective service delivery and efficient use of system resources. ITSD is charged with the design, development, operation, maintenance and ongoing enhancement of flexible automated information systems. The division provides technical assistance for problem resolution and evaluation and acquisition of hardware and software products.

Qualifications and Experience of Key Personnel: The Principal Investigator for *Building on Each Other's Strengths* is Chuck Halligan, MBA. Mr. Halligan is the current bureau chief for the Bureau of Children and Family Services, Division of Family and Community Services, Idaho DHW. Mr. Halligan has served Idaho families for 25 years with emphasis in the child welfare and children's mental health areas. This position manages family-centered programs including: Child Protection, Child Mental Health, Indian Child Welfare, Adoptions, Foster Care, and Family Preservation and assesses these programs for compliance with public policy such as Welfare Reform, Self-Reliance, and Title IV-B and Title IV-E.

The Project Director and State and Local Agency Liaison for *Building on Each Other's Strengths* is Decker Sanders, MPA. Mr. Sanders is the current senior project manager for the Children's Mental Health Service Delivery Project, Bureau of Children and Family Services, Division of Family and Community Services, Idaho DHW. Mr. Sanders brings experience spanning over twenty-three years with the Idaho DHW and the United States Air Force in areas including adult and children's mental health, substance abuse, and Equal Opportunity and Treatment.

Dr. Rick Phillips is currently the Director of Research and Evaluation, Idaho Child Welfare Center. Dr. Phillips will dedicate twenty hours per week (.5 FTE) to *Building On Each Other's Strengths*. This will be a natural progression for Dr. Phillips, moving from evaluation work with the three Idaho demonstration sites.

Dr. Sandra Altshuler, Associate Professor at the EWU School of Social Work, will dedicate twenty hours (.5 FTE) in joining Dr. Phillips in the evaluation of *Building on Each Other's Strengths*. Dr. Altshuler has completed numerous research projects and published journal articles on the health and well-being of at-risk children and youth.

Key Family Contact: to be contracted

Youth Coordinator: to be contracted

Technical Assistance Coordinator: Mardell Nelson, MSW, will dedicate an average of twenty (20) hours (.5 FTE) to *Building on Each Other's Strengths*. Ms. Nelson is a twenty-five year veteran of public service and former social work field director for Boise State University. She is currently a program specialist and supervisor for the Planning, Evaluation & Training Unit for the Division of Family and Community Services.

Communications Manager: to be hired

Administrative Support: Donna Allington

Percentage of time and rationale:

Mr. Halligan, in his role of principal investigator will dedicate an average of ten (10) hours per week (.25 FTE) to *Building on Each Other's Strengths*. This estimate is based on the delegation of the role of State and Local Agency liaison to the Project Director, review of *Building on Each Other's Strengths*' budgets and spending trends, direct supervision of the Project Director, representation of *Building on Each Other's Strengths* during ICCMH meetings, and attendance and travel associated with the "learning community."

Mr. Sanders, in his role as Project Director and State and Local Agency Liaison, will dedicate an average of forty (40) hours per week (1.0 FTE) to *Building on Each Other's Strengths*. This estimate is based on the complexity of recruiting, hiring, and directly supervising the staff of *Building on Each Other's Strengths*, facilitating and developing the strategic plan for implementation of the goals for *Building on Each Other's Strengths*, receiving and responding to inquires from Federal, State, and Local agencies. Coordination with the SAMHSA Project Officer, and monitoring of activities associated with the establishment and evaluation of councils at all levels of the system of care.

Drs. Phillips and Altshuler, in their role as key evaluation staff, will each dedicate an average of twenty (20) hours per week (0.5 FTE) for a combined total of eighty (80) hours per week (1.0 FTE) as required by the GFA. Their duties in working with the National Evaluation staff, preparing and implementing the evaluation plan for *Building on Each Other's Strengths*, and directly supervising 2.0 FTE evaluation staff support the combination of their efforts into the 1.0 FTE.

The 2.0 FTE evaluation staff will provide an average of 80 hours per week to *Building on Each Other's Strengths*. These staff, under the supervision of Drs. Phillips and Altshuler, will work directly with the ICCMH, seven regional, and multiple local councils in the implementation and monitoring of the evaluation plan throughout the state. This will require travel into remote areas of the State throughout the year.

The Key Family Contact, hired through a family-run organization, will provide an average of 40 hours per week (1.0 FTE) to *Building on Each Other's Strengths*. This position will incur significant travel time as family supports and implementation activities are conducted across the state.

The Youth Coordinator, hired through a family-run organization, will provide an average of forty (40) hours per week to *Building on Each Other's Strengths*. This position is critical for engaging youth in the system of care. The incumbent will spend the majority of the time in the development of contacts and the establishment of viable youth networks throughout the state.

The Technical Assistance Coordinator, Mardell Nelson, MSW, will dedicate an average of twenty (20) hours (.5 FTE) to *Building on Each Other's Strengths*. Ms. Nelson is a twenty-five

year veteran of public service. She is currently a program specialist and supervisor for the Planning, Evaluation & Training Unit for the Division of Family and Community Services. The Communications Manager, to be hired, will provide an average of forty (40) hours (1.0 FTE) to *Building on Each Other's Strengths*. This position is the central point for the development and implementation of the social marketing plan. Research activities, media development and production, preparing and monitoring contracts for media services, and working with the national technical assistance team are key responsibilities that will likely include significant travel.

Description of tasks and relationships:

- **Training:** The first step will be to develop a comprehensive training plan for the six-year grant. The Technical Assistance Coordinator will be responsible for developing the training plan in conjunction with the other partners. A six-year plan will be developed during the first year. The training plan will address cultural competency, family inclusion, system of care philosophy, development and services. *Building on Each Other's Strengths* will draw from the expertise of nationally recognized leaders in the field and existing curriculum such as "Core Curriculum in Community Based Care" by Human Services Collaborative.
- **Work Force Development:** One of the first activities will be to develop agency/parent/university focus groups to identify barriers and opportunities for enhancing system of care expertise in the current and future work force. Based upon the focus group information, strategies and a work plan will be developed. Efforts for in-service training will be coordinated with the training activities and plan. Pre-service training opportunities and curriculum development will occur at the university level.
- **Telehealth:** Idaho State University (ISU) Institute of Rural Studies was recently awarded a national Telehealth Grant to improve access to behavioral health services. ISU has adopted *Building on Each Other's Strengths* as a pilot. They will provide the *Building on Each Other's Strengths* with videoconference technology to support workforce development activities. We will also explore the feasibility of using this technology to deliver some children's mental health services in rural areas.
- **ICCMH:** These activities will focus primarily on regional and local council development, standards, annual report requirements, interagency state level coordination, and policy setting. They will take an active role as the governance body in over seeing the system of care development and evaluation.
- **Council Development:** The ICCMH will charter regional councils and develop a charter for the regional councils to use in chartering local councils. Each local council will do a baseline study of services in their area during the first year they are chartered. This information will be used to build service capacity over time to develop the component services for a system of care.
- **Parent Participation:** One of the primary duties of the Key Family Contact and the IFF will be to provide parent family perspective in the system of care. They will assist in recruiting additional parent representatives, training staff and parents, and providing input in system development and evaluation.

- **Social Marketing Campaign:** During the first year the Communications Manager will conduct research, work closely with the national technical assistance consultant, the Youth Coordinator, ICCMH, Key Family Contacts, cultural consultants, IFFCMH, regional and local councils and other stakeholders to develop the marketing messages and assure the messages are congruent with the system of care philosophy, are culturally sensitive and tailored to the intended audiences. Following years, the Communications Manager will develop, implement, and evaluate media campaigns and outreach functions.
- **Evaluation:** See Section D for specific activities.

Grant Specific Activities: Upon award, the project director and principal investigator will hire to any vacant positions and prepare a request for proposal to solicit a family run organization in establishing key family contact and youth coordinator positions. The project team, with input from stakeholders including family members, will detail project goals and tasks documenting them through the use of Microsoft Project software.

Tasks and Timelines:

Activities	Timeline	Responsible Person
Training		
Develop a training plan	Year 1	Technical Assistance Coordinator, ICCMH, agency training staff, university partners, parents
Cultural competency training will be developed and implemented for ICCMH, Regional and Local Council members, parents, providers	Year 1 & recurring	Technical Assistant Coordinator, Key Family Contact, cultural consultants
Develop and implement system of care training for ICCMH, Regional and Local Council members, parents, providers	Year 1 & recurring	Technical Assistant Coordinator & Key Family Contact
Attend National Technical Assistance – Learning Community meetings	Annually	Building on Each Other’s Strengths Core Team
Host Annual Statewide System of Care Conference	Annually	Technical Assistance Coordinator, ICCMH, agency training staff, university partners, parents
Develop and implement early identification training	Years 2 & 3	Technical Assistant Coordinator, Early Identification Workgroup & Key Family Contact
Develop and implement technology, data collection and evaluation training	Year 1 & recurring	Technical Assistant Coordinator, Key evaluation staff & Key Family Contact
Conduct Team Building and Collaboration Training and Facilitation	Year 1 & upon request	Technical Assistant Coordinator & Key Family

Activities	Timeline	Responsible Person
		Contact
Conduct parent led training and training provided by members of other cultures	Year 1 & recurring	Key Family Contact, IFFCMH, Technical Assistance Coordinator
Develop and implement training for parents and other caregivers on specific disorders and techniques to address them	Year 1 & upon request	Key Family Contact, IFFCMH, Technical Assistance Coordinator
Work force development		
Conduct campus focus groups	Year 1 & 2	Technical Assistant Coordinator & Key Family Contact, Workforce Development Workgroup
Establish university partnerships for conducting pre-service and in-service training	Ongoing	Technical Assistant Coordinator & Key Family Contact
Develop incentives and modify hiring practices to recruit, train and retain practitioners that are culturally competent and are ethnic minority members, relevant to the State of Idaho.	Years 3-6	Technical Assistant Coordinator, Key Family Contact, Project Director, Principal Investigator, and ICCMH
Telehealth		
Determine feasibility of using telehealth to deliver mental health services in rural areas	Years 1, 2 & 3	Project Director, Key Family Contact, Medicaid
Determine feasibility of using telehealth technology for delivery of training	Years 1, 2 & 3	Technical Assistant Coordinator & Workforce Development Workgroup
ICCMH		
Review membership to reflect cultural makeup of the state and parent members	Year 1	ICCMH and Project Director
Publish annual report	Annually	ICCMH, Regional and Local Councils
Develop standards for council implementation of services, confidentiality, membership, protocols and agreements which promote system of care principles and philosophy of intervention.	Year 1 and ongoing as needed	ICCMH
Implement data-based decision making and policy setting	Years 2-6	ICCMH, Regional & Local Councils, Project Director
Recommend social policy reforms that remove barriers to access and advocate for legislative support and resources	Year 2-6	ICCMH, Regional & Local Councils, IFFCMH
Review and validate CAFAS score levels	Annually	ICCMH, Project Director, Key Evaluators, State

Activities	Timeline	Responsible Person
		Planning Council on Mental Health
Council Development		
Develop charters for 7 Regional Councils	Year 1	ICCMH
Develop charters for local councils	Year 1	ICCMH
Review membership to reflect cultural makeup of region or community	Years 2-6	ICCMH
Establish baseline numbers for service capacity of local councils	Ongoing (during first year of individual council formation)	Local Councils, Key Evaluators
Gather data for the annual report published by the ICCMH	Annually	Regional and Local Councils, Key Evaluators
Develop and coordinate services such as respite, day treatment, therapeutic foster care, crisis response, culturally competent interpreters and providers, kinship care, natural helping networks etc.	Years 2-6	ICCMH, Regional, Local Councils, community members, Project Director, Key Family Contact, Youth Coordinator
Conduct a strengths based needs assessment and family centered, culturally competent, individualized case planning that reflects system of care philosophy	Years 2-6	Local Councils
Parent Participation		
Recruit parents for membership on the ICCMH, regional and local councils, and other workgroups	Years 1-6	Key Family Contact, ICCMH, IFFCMH
Integrate parent participation in the project evaluation	Years 1-6	Key Family Contact, Project Evaluators, Youth Coordinator, IFFCMH
Develop and implement parent led trainings	Years 1-6	Key Family Contact, Technical Assistance Coordinator, IFFCMH
Integrate parent participation in social marketing campaign	Years 1-6	Key Family Contact, Communication Coordinator, IFFCMH
Provide parental supports for the time they contribute to the development of systems of care and services	Year 1-6	Principal investigator, Project Director, IFFCMH, Key Family Contact
Social Marketing Campaign		
Develop a plan which addresses communications with the general public and improved communication among	Year 1	Communication Manager, Project Director, ICCMH, Key Family Contact, Youth

Activities	Timeline	Responsible Person
agencies and within the system of care. Plan needs to also address evaluation and mid-course corrections.		Coordinator, Councils, Cultural Consultants, communications contractor, IFFCMH
Conduct public education and outreach activities including but not limited to printed material, video productions, Public Service Announcements, press releases regarding activities of Initiative, linguistic and culturally relevant materials, 800 number, orientation materials, and partnership development	Years 2-6	Communication Manager, Project Director, ICCMH, Key Family Contact, Youth Coordinator, Councils, Cultural Consultants, communications contractor, Careline, IFFCMH
Contract for media campaign	Year 2-6	Communication Manager, Project Director, Principal Investigator
Compile and maintain list of books, web sites, support groups and other information sources for parents (how to get IEP, information on a specific disorder etc.) Develop links to all the agencies and partners	Years 1-6	Early childhood clearinghouse, IFFCMH, Communication Manager, Technical Assistance Coordinator
Participate as liaison to the National Social Marketing Campaign	Year 1-6	Communication Manager
Evaluation		
Develop participatory evaluation design	Year 1	Key Evaluation Staff, ICCMH, Key Family Contact, Youth Coordinator, IFFCMH, Project Director, council representatives, national evaluation consultant, family members
Data system development	Years 1,2 and 3	Key Evaluation Staff, Project Director, information system staff from agencies
Evaluation implementation	Years 1-6	Key Evaluation Staff, ICCMH, Key Family Contact, Youth Coordinator, Project Director, council representatives, national evaluation consultant
Participate in National Evaluation for Technical Assistance	Years 1-6	Key Evaluation Staff, Project Director, Key Family Contact, Youth Coordinator, Technical Assistance Coordinator
Grant specific Activities		

Activities	Timeline	Responsible Person
Hire staff	Year 1	Project Director
Contract for other key staff	Year 1	Project Director
Submit grant reports	Quarterly	Project Director
Participate in Technical Assistance Activities	Per schedule	Building on Each Other's Strengths Core Team

Facilities: Office floor spaces for the staff hired into DHW and contracted staff from the family-run organization for *Building On Each Other's Strengths* are located in the Pete C. Cenarussa building, downtown Boise. This ten story office building provides the lighting, heating and cooling, conference rooms with conference telephones and local computer/internet access for groups from 7 to 35, and restrooms for Department employees. Telephone service is available with long distance services billed at DHW's "bulk" rates for calls placed from individual workstations. DHW's computer network links all DHW offices statewide via email, proprietary intranet, and high-speed internet.

Contracted evaluation staffs are based at Eastern Washington University, Cheney Washington and the Idaho Child Welfare Training Center, Coeur d'Alene, Idaho. The facilities include office space, lighting, heating and cooling, telephone service, and personal computer workstations connected via on-campus networks and high-speed internet services.

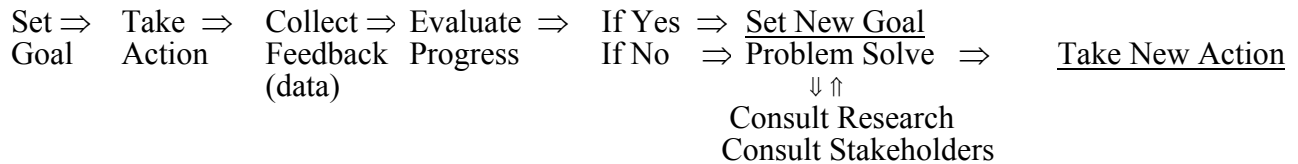
Compliance with Americans with Disabilities Act (ADA): Services provided through the facilities owned and managed by the DHW are compliant with the ADA. Providers of direct services for *Building on Each Other's Strengths* meet eligibility criteria for Medicaid providers. The DHW administrative rules (Idaho Administrative Procedures Act, Title 16 Chapter 03 Section 525) governing facility standards for Medicaid approved facilities requires conformity with the ADA.

SECTION D: EVALUATION PLAN

Building on Each Other's Strengths will implement a participatory evaluation plan that integrates at all levels the setting of goals with measurements of program and client progress. This goal setting will be an integral component of the *Building on Each Other's Strengths*. Not only will youth and families set goals and work with the evaluation to establish measurements around those goals, but providers working in collaborative teams will also set goals that will help them measure their progress on building a system of care. Because participatory evaluation uses participants as resources to their own progress, it is crucial to use existing, local sources of information as formative feedback data into the collaborative process. It is also important that evaluation methodologies be user-friendly, culturally sensitive, and simple to implement.

The participatory process begins when stakeholders (e.g., local, regional and state agency personnel, parents, children, school personnel, community members, etc.) define outcomes they value, learn to describe indicators and to collect a variety of information to determine success in reaching the outcomes. The program outcomes will serve as guidelines and long-term targets for such goal setting. Next, a template will be created for measuring the progress of the indicators derived from the various sources, and periodic measurements will be used as feedback to inform the decision making process of the stakeholders.

A goal of participatory evaluation is to ensure that the evaluation process itself becomes an integral component of the system of care at every level. The evaluation team does not independently collect data. Over time system of care participants learn how to plan for and manage a data collection system. Moving through this process, the evaluators shift to the role of facilitator, while maintaining responsibility for ensuring that the system of care preserves the standards adopted by the state and/or targeted by *Building on Each Other's Strengths*. The action chart below shows a process by which local teams with parents can learn to process their own activities and outcomes. The evaluation team will work with sites to implement this continuous improvement cycle:



Two types of outcomes, functional and representational, will be assessed using multiple measurement approaches drawing on multiple sources of information. Functional outcomes are defined as those obtained from the youth and parents' own definitions of success. These outcomes are measured by non-standardized, self-anchored tools and are sensitive to smaller changes in behavior over shorter periods of time. Functional outcomes will be tracked as a part of the participatory process of working with families and providers. The aggregation of functional outcome measurements provides another way to triangulate program impact when combined with standardized assessments and family/provider feedback.

Representational outcomes are more global and result from using standardized, norm-referenced measurement tools, such as CAFAS. Representative outcomes provide information for aggregate evaluation, thus aligning with the major goals of *Building on Each Other's Strengths*, the national evaluation, and with the components of a system of care to provide a continuous report card on the extent to which *Building on Each Other's Strengths* is successful in its goals. Representative outcomes will be tracked to provide measurements of program effectiveness for planning and policy making purposes and to fully participate in the national evaluation. An example of representative outcomes is contained within the CMH Service Definitions & Measures table (ref. Section B).

A goal of the evaluation plan is to provide a rich description of the process of implementation along with a clear picture of the outcomes achieved so that stakeholders can sustain the activities and process. A multiple case study with replication design will form the basic evaluation plan, utilizing each site as a single case study around commonly embedded themes and evaluation objectives and *Building on Each Other's Strengths Initiative* goals. The case study format will include contextual information necessary for translating to similar locations. The collaborative creation of program/team progress rating scales based on identified community and client needs will provide a matrix that can be shared with other sites. In addition, representative outcomes from the national evaluation will be coupled with localized process data to better understand the variables involved in building a system of care. The seven regions of the state will provide a natural reporting structure for yearly progress reports, which will be aggregated for yearly state-wide reports. A goal of the 6-year evaluation would be to support development of a results-oriented management style within the local collaborative teams. An anticipated outcome of interim and final reports will be sharing information at state and national levels.

Extent to which evaluation activities/procedures will assure successful implementation of the national evaluation and integration of national evaluation data into the system of care

process: The Idaho initiative includes current and developing evaluation activities that align well with the national evaluation. The proposed state evaluator is currently working with three demonstration sites to develop a comprehensive system of care evaluation. The pilot database will be in place before Sept. 02. Categories of targeted information include a) system of care process and outcome data; b) MIS data relating to client descriptors and units of service; c) eligibility indicators; d) baseline and post data for descriptive and inferential statistical analysis; and e) satisfaction data.

An evaluation team led by experienced, Ph.D. level evaluators will train 7 regional councils members in data collection procedures and then work collaboratively with them and local councils to assure quality data collection in a timely manner, both in terms of the national evaluation procedures and the local evaluation process. System wide procedures will allow for quarterly reports on activities, along with annual reports on outcomes and satisfaction.

Managing by data: Data provided by the national evaluation and the local evaluation will be used as feedback to the system of care at all levels. Contextualized local data, combined with national evaluation data, may provide policy makers and program managers with the information necessary to make state level decisions based on localized needs. National evaluation data will also serve as a learning tool for local councils to better understand their impact on clients. As described above, the evaluation design includes a participatory evaluation orientation that integrates and coordinates stakeholder participation in evaluation activities at every level. Although some data elements are identified in advance, the means and process of collecting the data will involve local, child and parental input; standardized instruments will be delivered with great fidelity as a result of consumer buy-in to the data that they provide. Trainings and consumer input will help system developers and evaluators recognize quality assurance needs, and a results-oriented data management system at each level of the system will produce continuous feedback as to program effects.

Knowledge and experience of evaluation personnel: Idaho has a three-year history with EWU for evaluating children's mental health programs. The EWU-Idaho Child Welfare Research and Training Center employs the lead evaluator for this initiative to work in all regions of the state and that person has worked in-depth with local community mental health councils in three of the regions, including working with parents and children. In addition, the evaluator has been a facilitator in bringing together a wide range of collaborators and partners, including parents, throughout the state. In addition, the lead evaluator for the Idaho Center has produced three years of state-wide reports on a major children's mental health initiative, along with regional studies that used inferential statistics to analyze program effects. Currently, the evaluator is collaborating with Idaho DHW to publish a seven year report on the Community Resources for Families program. This person has recently published articles on both methodology and program effectiveness studies. In addition, multiple national presentation of evaluation findings have occurred in each of the past three years.

A second Ph.D. level evaluator for this initiative has worked extensively in child welfare and school social work to support the mental health needs of at-risk children and youth. She has been the principal investigator on a number of research projects that have directly involved youth and families in creation, implementation, reporting and dissemination. In addition, this person has published over one dozen articles in peer-reviewed journals, all focusing on varying aspects of children's well-being, including mental health, school functioning and health status, received grant funding for two different research projects from the Univ. of Illinois' Center for Research on Children to evaluate the health and well-being of youth living in, and transitioning from, the child welfare system, and been appointed to the Editorial Board of two prestigious social work journals, both of which focus on the needs of children and adolescents.

Facilities and equipment devoted to the evaluation: Idaho is well equipped to begin the evaluation process of this initiative. It is also well equipped to learn from the process and change its data management system to incorporate a more sophisticated version of a comprehensive evaluation including community input and feedback. In particular Idaho currently has a completed, statewide ACCESS MIS system located within the DHW that tracks mental health services throughout the state. The ACCESS system is currently being transitioned into a statewide FOCUS system that will provide additional capacity for tracking, storing, and sharing data at all levels. Past experiences in working with the ACCESS system has shown that statewide data bases can be analyzed using SPSS or other statistical software. Currently, all evaluation activities are well supported by state funds or contracts between Idaho DHW and EWU School of Social Work.

Functions of data entry: The evaluator will design a data collection system that flows naturally from client to evaluation personnel. Key elements will include:

- Hiring and training evaluation personnel to work on-site with local service teams and parents to design routines and instruments that are valued by local stakeholders.
- Ensuring that data collection on individual cases acquires confidential status as it is reported to evaluators and as it is used in team decision making.
- Ensuring that data is stored by client number and not client name, and that the client master list is stored separately from the database and only accessible to the evaluation team.
- Data management, analysis, and reporting will be coordinated with the statewide FOCUS database. Quarterly data summaries will be sent to evaluators, and data files will be assigned identification numbers for aggregation purposes.
- All client or agency surveys will be kept in a locked file cabinet in a locked office room in the School of Social Work at Eastern Washington University to which only evaluation staff have entry. Completed survey instruments will be hand carried to the office by evaluation personnel. If survey data is transmitted over email, it will be anonymous feedback data.

Data currently available in the MIS system include:

- diagnostic, assessment, and treatment planning data
- demographic and family situation data
- history of treatment data
- services delivered and agencies involved
- timeframe of services delivered

Currently, DHW has access to the statewide database. Other collaborating agencies maintain their own databases. It is believed that the feasibility of sharing databases is good, especially as state level policy makers are able to coordinate HIPPA requirements within the local children's mental health collaborative teams.

Family members and youth incorporation: The local evaluation will utilize a participatory design that allows local parents, children, and community collaborators to give input into both the design process and the product of local feedback instruments. Local teams, including parents and children, will be asked to target goals of service delivery and rate the value of potential outcomes of service. These goals and indicators will become part of the feedback process to local children's mental health collaborative teams. In addition, regular focus groups run by experience evaluators will collect on-going needs assessment and satisfaction data that will be shared local provider teams. Lessons learned and critical case review data will be gathered from parent participants on a regular basis. In addition, individual cases will be utilized as single case studies for the sake of applying qualitative analysis to lived experiences; the results will be aggregated over time using a qualitative case study design that compares needs with patterns of results.

In this regard, the formation of local councils as case management teams fits well into a process for collecting sensitive and localized needs assessment and feedback data. Training will go on continuously to assure that local teams understand and honor the inclusive, multicultural environment necessary to collecting valid data in group situations. In addition, the evaluation team will actively participate in data collection sessions as part of the evaluation routine.

Local evaluation efforts: Evaluation activities will concentrate on implementing and supporting a participatory evaluation process throughout the state of Idaho and at every level of program implementation. At every level, participatory and localized information will accompany national evaluation data to help contextualize the aggregated national evaluation data from different regions within the state. In addition, to the greatest extent possible, local feedback and goal setting data will be coordinated with the goals of the national evaluation target data, so that parents and children have a voice in interpreting that data. The process of implementing participatory evaluation procedures within the children's mental health arena has already begun in Idaho, and one of the lead evaluators has been the principle agent for promoting this approach.

Institutional Review Board: Both principle evaluators for this project are Associate Professors at Eastern Washington University (EWU), the institution that will be used as the agent for IRB approval for the project. EWU has worked with the State of Idaho during the past several years on projects that required IRB approval, and Dr. Phillips has been the author of three successful IRB applications that have included a participatory orientation. Previous to her position at EWU, Dr. Altshuler worked at the University of Illinois at Urbana-Champaign (UIUC) as a faculty member in the School of Social Work. In that position, Dr. Altshuler has been the author of five successful IRB applications at UIUC, all of which involved children directly in the collection of data.

SECTION E: BIBLIOGRAPHY

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SECTION F: BUDGET
 DETAILED WORKSHEET FOR COMPLETING
 SF 242A: SECTION B FOR 01 BUDGET PERIOD

OBJECT CLASS CATAGORIES

Personnel

Job Title	Name	Annual Salary	Level of Effort	Salary being Requested
Principal Investigator	Charles Halligan	64480	0.25	16120
Project Director	Decker Sanders	63773	1	63773
Communications Manager	Unnamed	43139	1	43139
Administrative Assistant	Donna Allington	30222	1	30222
Technical Assistance Coordinator	Mardell Nelson	43139	0.5	21569

Subtotal (Salary) \$174,823

Fringe Benefits (33%)

Subtotal (Fringe) \$ 57,692

Travel

3 trips for SAMSHA Meetings for 6 Attendees (airfare @ \$1195 x 6 = \$21510) + (per diem @ \$55 x 5 x 6 x 3 = \$4950) + (lodging @ \$135 x 4 x 6 x 3 = 9720) + (ground transport @ \$100 x 6 x 3 = \$1800) + (parking and tolls @ \$9 x 6 x 3 x 5 = \$810)

\$38,790

6 in-state trips for council development and monitoring for 2 Attendees (airfare @ \$298.20 x 6 x 2 = \$3577.20) + (per diem @ \$25 x 40 = \$1000) + (lodging @ \$79 x 36 = \$2844.00) + (ground transport @ \$45 x 3 x 2 x 6 = \$1620.00) + (parking and tolls @ \$9 x 2 x 36 = \$648)

\$9,689

Subtotal (Travel) \$48,479

Equipment

Desks (4 @ \$1200.00 = \$4800.00)
Personal Computing Workstations
(5@ \$1320.00 = \$6600.00)

Subtotal (Equipment) \$11,400

DETAILED WORKSHEET FOR COMPLETING
SF 242A: SECTION B FOR 01 BUDGET PERIOD

Supplies

Computer Software (Microsoft Visio Standard \$123
x 2 = \$246) + (Microsoft Project 2000 \$271 x 2 =
\$542) + (Attachmate Extra! \$265 x 4 = \$1060)
+ (Employee Appraiser \$95 x 2 = \$190) **\$2,038**

Desk Chairs (4@ \$450.00 = \$1800.00) **\$1,800**

Side Chairs (8@ \$200.00 = \$1600.00) **\$1,600**

File Cabinets (3 @ \$125.00 = \$375.00) **\$375**

Office Supplies **\$1,500**

Long Distance Telephone (12 mos. @ \$30) **\$360**

Postage (\$25.00/ Qtr.) **\$100**

Photocopies **\$100**

Total (Supplies) \$7,873

Contractual

EWU

Personnel

Evaluator	Rick Phillips	60915	0.5	Total	30,458
Evaluator	Sandy Altshuler	67751	0.5		33,876

Benefits

33% of salaries 21,230

Travel

Airfare	7 sites/quarter 3 national sites	<i>cost</i> 700	<i>days</i>	4,200
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Lodging	3 Idaho sites		356		2,136
	National		135	4	3,240
	Idaho		79	3	1,422
Per Diem	National		55	5	1,650
	Idaho		25	4	600
Ground Tr.	National		100	1	600
	Idaho		25	3	450
Parking/Fuel	National		9	5	270
	Idaho		9	3	162
Supplies	\$30/month				360
Services					
Long Distance Telephone		\$30/mo			360
Postage		\$25/qtr			100
Photocopies					100
Subtotal					101,213
Indirects	58% of total				58,703
Total					159,916

Regional Universities					
MSW Evaluator Salary		2 empl at .5FTE/Univ.			70,000
MSW		@ \$35,000			
Benefits		33% of salary			23,100
		\$20/mo x 2			
Supplies		x12 univ.			480
Services		1/2 EWU costs/univ			1,120
Travel					
(regional)	Mileage	400 mi rt x 8 trips x .365/mi /univ			2,336
	Per Diem				
subtotal					97,036
indirects @ 58%					56,281
Total					153,317

Family-Run Organization

Personnel					
	Key Contact	Unnamed	39520	1	39,520
	Youth	Unnamed	24960	1	24,960
					Total

Coordinator

Benefits

33% of salaries 21,278

Travel

	7 sites/quarter	<i>cost</i>	<i>days</i>	
Airfare	3 national sites	700		4,200
	3 Idaho sites	356		2,136
Lodging	National	135	4	3,240
	Idaho	79	3	1,422
Per Diem	National	55	5	1,650
	Idaho	25	4	600
Ground Tr.	National	100	1	600
	Idaho	25	3	450
Parking/Fuel	National	9	5	270
	Idaho	9	3	162

Supplies

\$30/month 360

Services

Long Distance Telephone	\$30/mo	360
Postage	\$25/qtr	100
Photocopies		100

Subtotal 101,408

Indirects 58% of total 58,817

Total

160,225

Training

Statewide Children's Mental Health & System of Care Conference

Rent: (4 Meeting Rooms @ 200 person capacity x 2 days x \$550/day = \$4,400 + 1 Grand Ballroom x 2 days x \$700 = \$1,400 + audio visual support @ 5 rooms x 2 days x \$35/day = \$350)

\$6,150

Nationally distinguished presenters: (6 presenters @ \$1500/day x 2 days = \$18,000) + (printed materials @ 500 sets x \$25/set = \$12,500)

\$30,500

Technical Assistance Sites: (6 sites x 1 meeting room x 2 days @ \$350/day = \$4,200) + (6 consultants @ \$1300 x 2 days = \$15,600) + (airfare @ \$700 x 2 x 6 = \$8,400) + (per diem @ \$25 x 2 x 6 = \$300) + (lodging @ \$79 x 2 x 6 = \$948)

\$29,448

Social Marketing
Research, Development and Production **\$50,000**

Subtotal (Contractual) \$589,556

Other

Information System Integration for CMH
50 function points @ 36hrs@\$50 hr/point = \$105,000.00

Subtotal (Other) \$90,000

Total Direct Charges \$979,823

Indirect Costs \$19,596

Estimated at \$19,603. Final indirect charges will be as calculated through use of federally-approved cost allocation plan.

TOTALS \$999,419

JUSTIFICATION

Personnel: Listings of job descriptions and primary roles are contained in Section G.
Principal Investigator: Responsible Officer for the fiscal and administrative oversight of the cooperative agreement. Duties and responsibilities are consistent with the position of Children's and Family Services Bureau Chief. Salary range: \$51,001 to \$79,705.

Project Director: Responsible to hire staff, develop a strategic plan to meet objectives, provide leadership in all facets of the development of the system of care. Duties and responsibilities are consistent with the Position of Senior Project Manager. Salary range: \$51,001 to \$79,705.

Communications Manager: Responsible for the research, development, and deployment of a targeted mass media campaign focused toward children with SED and their families. Duties and responsibilities are consistent with the position of Public Information Officer. Salary range: \$34,507 to \$53,934

Technical Assistance Coordinator: Responsible to assess training and technical assistance need, research and identify appropriate sources for training. Develop, design, and conduct training as required. Duties and responsibilities are consistent with the position of Training Specialist. Salary range: \$34,507 to \$53,934

Administrative Assistant: This position independently researches, analyzes, and compiles information to prepare reports, handle complaints, or resolve problems; compose correspondence

for the Project Director on own initiative or from general instructions; format/type a variety of executive, sensitive, confidential, official and/or legal letters and documents. Duties and responsibilities are consistent with the position of Administrative Assistant 2. Salary Range: \$23,982 - \$37,772

Fringe Benefits:

Group Insurance
Worker's Compensation
Employer Retirement
Sick Leave

Equipment:

Personal Computing Workstations: required for word processing, database design and management, Internet access, and administrative functions. System specifications and costs taken from the DHW IT supported hardware and software listing.

Desks: Required workspace

Travel:

Central to the development of a statewide system of care is the development of local councils throughout the communities Idaho. Once established, councils will require monitoring for both clinical and fiscal compliance. The budget contains funding for up to 6 trips for the Project Director and other members of the staff to travel across the state in the development and monitoring of the councils and contractors.

Supplies: Self-explanatory

Contractual Costs: The 3 FTE set aside for evaluations are contracted through Eastern Washington University.

The research staff at EWU will design an outcomes based evaluation of Idaho's attempt to establish a systems of care model across the state. Further, EWU evaluation staff will work in conjunction with the National Evaluation Technical assistance Team.

The family-run organization will provide the needed positions of the key family contact and youth coordinator. This is essential to the project's efforts to engage children and parents all levels involved with their child's needs and service planning.

Facilities and support services are contracted for the Children's Mental Health Conference. This statewide training opportunity provides a forum for parents, children, and providers the opportunity to learn about the latest in the system of care.

Other:

This line item provides for the development of an advance planning document to detail the challenges and costs to bring the current, badly fragmented IT system for Children's Mental Health into a single comprehensive client information system. This one item is certain to increase in cost over the next two years as work moves from the design to implementation.

CALCULATION OF FUTURE BUDGET PERIODS

Increases in years two and three are centered on the further development of the client information system for children's mental health and the increased costs to the social marketing campaign as it moves from research, development, and production to broadcasting and print space purchase.

Along this same line, the decreases projected in years 4, 5, and 6 are the result of the move from development to maintenance in the information system portion of the project.

SECTION G: BIOGRAPHICAL SKETCHES AND JOB DESCRIPTIONS

Principal Investigator:

Purpose: To develop and manage Family and Children's programs providing statewide community-based services; serves as the state's expert providing leadership for treatment and intervention programs of at-risk children; perform related work.

Nature and Scope: This position manages family-centered programs including: Child Protection, Child Mental Health, Indian Child Welfare, Adoptions, Foster Care, and Family Preservation.

This position assesses Family and Children's Services programs for compliance with public policy such as Welfare Reform and Self-Reliance and to ensure that the needs of Idaho's citizens are met. Implements quality assurance and quality improvement measurements.

This position represents the Department of Health and Welfare by providing statewide leadership, and technical expertise, making presentations, and negotiating with the Indian tribes, legislature, federal government, service providers, other state agencies, public officials, and the public regarding programs for families and children. This position is the state's Child Mental Health authority. This position develops and interprets laws, rules, and policies and conducts negotiated rule making hearings. The Bureau Chief coordinates with parents, the Departments of Education and Juvenile Corrections, and other related agencies to promote family involvement and responsibility in treatment programs for at-risk children. Authorizes investigation of suspected cases of malfeasance. The Bureau Chief provides technical support, liaison, and coordination with the Governor's Task Force and other related committees.

This position develops and controls the budget for the bureau and provider contracts; hires, trains and evaluates the performance of bureau staff and consultants; directs the development and implementation of training for all staff working with family and children's services statewide.

Minimum Qualifications: Considerable knowledge of: child welfare, child mental health and child and family social services laws, theories, programs and practices. Good knowledge of: management practices, contract/grant administration.

Experience: supervising professional staff in children's social services and mental health programs in a community-based setting; social services project management; developing and/or monitoring budgets.

Salary Range: \$51,001- \$79,705 **Hours:** 2080 hours per year (40 hours per week)

Chuck Halligan
3811 S. Suntree Place
Boise, Idaho 83706
208 334-6559

Education

Education Boise State University - Boise, Idaho. Masters in Business Administration. Beta Gamma Sigma member.

Boise State University – Boise, Idaho Bachelor’s Degree in Social Work

Professional Experience 2000 to Present – Idaho Department of Health and Welfare, Family and Children’s Services, Bureau Chief. Responsible for the day to day operations of the Bureau of Family and Children’s Services central office staff and programs. Administrative and budget responsibilities for children’s mental health, child protection, adoptions, foster care, independent living, Indian child welfare, and foster care funding programs. Legislative and federal contact for these programs.

1997 to 2000 – Idaho Department of Health and Welfare, Family and Children’s Services, Program Specialist for the FOCUS Project. Implementation coordinator responsible for planning, coordinating, scheduling, and monitoring the implementation of a statewide information system for Family and Children’s Services.

1991 to 1997 – Idaho Department of Health and Welfare, Family and Children’s Services, Program Specialist. Various duties within the Bureau including the adoption program, foster care, Title IV-E foster care funding, training, group home contract negotiating and monitoring, and legislative duties. Responsible for monitoring \$4.5 to \$5 million budget for group care contracts.

1977 to 1991 – Idaho Department of Health and Welfare, Family and Children’s Services, Social Worker. Direct service duties included children’s mental health, child protection, adoption, juvenile probation, juvenile justice committed youth, and adult services. Worked in various locations in the state from 2 person offices to the largest office in the state.

1976 to 1977 - Sunrise House, Assistant Manger. Provided residential shelter care supervision and services to delinquent youth referred by Ada County Juvenile Court Services and Idaho Department of Health and Welfare.

Project Director:

Purpose: To manage major projects with statewide/department impacts; perform related work.

Nature and Scope: This is the expert-level project manager classification. These projects require the incumbent be an expert in project management, including the planning, development, implementation, and evaluation of large, complex projects. Incumbents supervise project staff and provide direction to a large and diverse project team. They direct the development of project goals, work plans, timelines, and implementation strategies. They direct the identification of decision-making issues, key stakeholders, development and implementation of strategies to encourage and obtain stakeholder and/or community support, and identification of project partners. Incumbents manage and are accountable for project budgets and contracts.

Minimum Qualifications: Considerable knowledge of: social, psychological, or rehabilitative services, principles, and methods.

Experience: managing staff; managing major projects including development of project scope, goals, work plans, timelines, and implementation strategies; developing measurement processes/methods for assessing progress toward goals and project outcomes; preparing and presenting oral presentations to groups; developing and monitoring contracts; working with public social/rehabilitative service delivery systems; planning, implementing, and overseeing a community-based social/rehabilitative service program to include community organization; writing management reports based on the evaluation/monitoring of an evaluating social/rehabilitative service.

Specialty Area: experience managing a public welfare program; experience demonstrating considerable knowledge of health and human services delivery and regulatory systems, including good knowledge of federal and state medical assistance programs and related laws and regulations; good knowledge of the design, capabilities, operations and federal certification requirements for integrated automated systems currently used by Welfare programs and their interfacing automated systems.

Salary Range: \$51,001- \$79,705 Hours: 2080 hours per year (40 hours per week)

Decker L. Sanders
140 West 15th North
Mountain Home, Idaho 83647
(208) 587-9470 tsanders@fiberpipe.net

PROFESSIONAL SUMMARY

Over two decades of government service with increasing responsibilities in sensitive positions
Expert management of a high profile, large, and complex department enterprise project
Five years experience leading and managing comprehensive public sector addiction programming

Two years guiding Equal Opportunity and Treatment, drug and alcohol, and drug testing programs

Over seven years managing and developing electronics personnel with resources in excess of \$23M

Over six years in law enforcement, four as Master Technical Instructor at USAF Police Academy

WORK HISTORY

2001-Present Senior Project Manager, Idaho Department of Health and Welfare
Earned project management certification by examination under International Organization for Standardization (ISO 9001) guidelines. Guided staff assigned to a multi-year enterprise project to achieve first year goals significantly under projected workload and budget. Organized large, diverse project teams and stakeholder workgroups ensuring comprehensive policy and standards development. Ensured project goals, work plans, timelines, and implementation strategies met court monitored standards of performance. Minimized delays resulting from changes in the internal and external environments by providing early project risk analysis, issues identification, and decision points to project sponsors.

1999-2001 Program Specialist, Idaho Department of Health and Welfare
Expertly balanced competing state, federal, and public interests into the first comprehensive tobacco enforcement program in Idaho. Envisioned and directed the development of the first web-enabled service for the Division of Family and Community Services. Skilled communicator for senior staff, public interest groups, federal officers, and legislators on issues and outcomes through television interviews, public speaking, and legislative testimony. Authored the Federal Substance Abuse Block Grant application and other proposals, prepared requests for proposals, negotiated and monitored contracts totaling over ten million dollars for statewide addiction programming. Promulgated rules from draft language to final legislative adoption. Developed “best practice” standards and performed quality assurance and peer reviews of service delivery programs.

1995-1998 Director, Substance Abuse Control Program, Mountain Home AFB, ID
Created the transition plan used to merge substance abuse didactic programs into the mental health services six months ahead of schedule. Mentored a staff of 5 certified professionals conducting substance abuse prevention, treatment, and random drug testing programs for military personnel and their families. Fostered development, production and evaluation of

specialized training materials used in substance abuse programming. Networked drug prevention programs with the community. Initiated, maintained, and disposed of client records. Forecast program budget, authorized expenditures, and reconciled budget.

1993-1995 Department Head, Social Actions, Mountain Home AFB, ID
Only the second non-commissioned officer ever named to the Commanding General's staff for Equal Opportunity and Treatment / Substance Abuse control programs. Independently audited 17 discrimination and sexual harassment complaints ensuring through investigation and appropriate recommendations supported by case documentation. Researched and conducted climate assessment surveys resulting in specialized diversity training for new personnel and unit specific problems. Established the first Social Actions team designed to provide cultural analysis and situational support for deployed commanders. Developed partnerships between other base and community referral agencies. Forecast program budget, authorized expenditures, and reconciled budget.

FORMAL EDUCATION

2000	Master of Public Administration	The University of Oklahoma
1995	Bachelor of Science, Social Psychology	Park University
1993	Associate of Applied Science, Social Services	Community College of the Air Force
1992	Associate of Applied Science, Avionics Technology	Community College of the Air Force
1992	Associate of Applied Science, Security Administration	Community College of the Air Force

OTHER

2000	The Fifth Discipline Welfare	Department of Health and
1999	Mediation Facilitation Consultants	Professional Mediation
1997	Quality Teams Facilitator and Tools Course	USAF Quality Center
1994	Seven Habits of Highly Effective People	Covey Leadership Center
1993	Quality Empowerment Course	USAF Quality Center

CERTIFICATIONS

2002	Project Management
2002	Human Resource Concepts (United States)
1998	Critical Incident Stress Debriefing Team Member
1996-1999	Certified Alcohol and Drug Abuse Counselor

PROFESSIONAL ASSOCIATIONS

2000	American Disabled Veterans
1998	American Society for Public Administration

Richard D. Phillips, Ph.D.
Associate Professor of Education

1. Academic Degrees

Ph.D. University of Washington 1995 Educational Leadership and Policy
Studies: Evaluation Specialist, Center for the Study
and Teaching of At-Risk Students (C-STARS) Univ. of
WA

Univ. of St. Thomas (MN) 1991 Education Administration Certificate

M.A., B.A. Univ. of Helsinki, Finland 1975 English, Philosophy, Linguistics

2. Current Professional Experiences

2001 - 2002 Director of Research and Evaluation, Idaho Child Welfare Center
Director, EWU 21st Century Masters of Education Program
Director, EWU National Board Teaching Certificate Program
NCATE Assessment Director, EWU Department of Education
Evaluation Consultant: Spokane (WA) School District #81:
Special Programs Evaluation Consultant: ESD 101 (Spokane, WA): Prevention
Center

3. Recent Evaluations 2000 - 2001

Position Director of Research and Evaluation, Idaho Child Welfare Center

Evaluations Idaho Statewide Community Resources For Families Program
Idaho Region 1 Latino Outreach Project
Idaho Region 1 CRFF Sample Program Study

Position Independent School District #81, Spokane, WA

Evaluations 21st Century Community Learning Center Program (National Grant)
Substance Abuse Specialist Support Program (State grant)
Summit School Substance Abuse Recovery Program (State grant)

Position ESD 101, Spokane, WA:

Evaluations 21st Century Community Learning Center Program (National grant)
Prevention/Intervention Specialist Program (State grant)
Middle School Coordinator Program (National Grant)

Pend Oreille Safe School/Healthy Students Program (National Grant)

4. Recent Publications

Community Resources For Families Program: Using Client Outcomes to Measure Program Success. (accepted for publication, March 2002). (Book chapter: Advances in School Based Mental Health).

Moving Toward Collaboration: Funding as a Source of Change in Child Welfare. (accepted for publication, Dec. 2000). Journal of Social Research.

Resources for Families Program Evaluation (2000). Eastern Washington University/State of Idaho Department of Health and Welfare

Kenai Peninsula Borough School District: Family Support Program
(Program Evaluation Report) (1999). University of Washington

Using Critical Case Reviews to Analyze Interprofessional Case Management Team Decisions (1997). Preventing School Failure

SANDRA J. ALTSHULER, Ph.D., L.C.S.W., A.C.S.W.

Extremely Shortened Vitae

EDUCATION

- Ph.D. 1996 Jane Addams College of Social Work, University of Illinois at Chicago
- M.S.W. 1985 Jane Addams College of Social Work, University of Illinois at Chicago
- B.A. 1981 University of Illinois at Urbana-Champaign (History)
Magna Cum Laude, High Distinction In History

PROFESSIONAL EXPERIENCE

2000-present *Associate Professor*, School of Social Work, Eastern Washington University
Instruct master's level social work courses: foundation knowledge and ethics; individual, group, family practice and policy; advanced clinical practice with families, children and adolescents; and research.

Conduct various research projects, report and disseminate findings in peer-reviewed professional journals and at conferences.

TEACHING AND PROFESSIONAL EXPERIENCES

1996-present *Assistant Professor*

School of Social Work, University of Illinois at Urbana-Champaign

Instruct master's level semester courses: School Social Work Practice; Social Work Interventions with Children and Adolescents; Practice Evaluation: School Social Work; Comparative Approaches to Social Group Work.

Conduct various research projects, report and disseminate findings in peer-reviewed professional journals and at conferences.

1993-95 *Research Assistant, 50% appointment*

Jane Addams College of Social Work, University of Illinois at Chicago

1989-93 *School Social Worker, Coordinator of Student Support Team*

District 102 (K-6), LaGrange Park, Illinois

1987-88 *Coordinator, Counseling Department*

Blue Gargoyle Youth Service Center, Hyde Park, Illinois

1985-87 *Clinical Social Worker, Medical Unit Coordinator*

Response Center, Jewish Children's Bureau, Chicago, Illinois

Selected Examples of Research and Scholarship

Publications (Journal articles, technical reports)

Altshuler, S.J. & Kopels, S.L. (In press). Advocating in schools for children with disabilities: What's the new I.D.E.A.? *Social Work*.

Altshuler, S.J. & Poertner, J. (In press). The A Child Health and Illness Profile: A New Tool for Assessing Well-Being in Group Homes or Institutions. *Child Welfare*.

Altshuler, S.J. (In press). When is mentoring not helpful for students living in foster care? *School Social Work Journal*

Altshuler, S.J., & Gleeson, J.P. (1999). Completing the evaluation triangle for the next century: What is Achild well-being@ in family foster care? *Child Welfare*, 78, 125-147.

Altshuler, S.J. (1998). Child well-being in kinship foster care: Similar to, or different from, non-related foster care? *Children and Youth Services Review*, 20(5), 369-388.

Altshuler, S.J. & Poertner, J. (2000). *The Child Health and Illness Profile Adolescent Edition: A New Tool for Assessing Well-Being in Foster Care*. Urbana, IL: University of Illinois at Urbana-Champaign, Child and Family Research Center.

Altshuler, S.J. (1998). *Final Report: An Evaluation of a Teachers as Mentors: A Program for Students Living in Foster Care*. Urbana, IL: UIUC.

Gleeson, J.P., Bonecutter, F.J., O'Donnell, J., & Altshuler, S.J. (1997). *Final Report: Achieving Permanency for Children in Relative Foster Care*. Chicago, IL: UIC, Jane Addams College of Social Work and the Jane Addams Center for Social Policy and Research.

Grant Activities

1997-00 Co-Principal Investigator, Comparing Health and Well-Being Across Populations in Care, Children and Family Research Center, UIUC (Funded at \$196,000)

1998-00 Co-Principal Investigator, The Illinois Youth Study: Aging Out of Care, Children and Family Research Center, UIUC (Funded at \$250,100)

Professional Presentations

June, 2001 *From barriers to successful collaboration: Public schools and child welfare working together*. Child Welfare League of America Western Conference, Denver, Colorado

January, 2001 *Lessons Learned: An Evaluation of a Teachers-As-Mentors Program for Children Living in Foster Care*. 5th Annual Conference of the Society for Social Work and Research Atlanta, Georgia

September, 2000 *The Child Health and Illness Profile Adolescent Edition: A New Tool for Assessing Well-Being in Foster Care*. (presented with J. Poertner) Child Welfare League of America conference, Snowbird, Utah

October, 1998 *Supporting the Educational Success of Students Living in Foster Care* 1998 Midwest School Social Work Conference, St. Louis, Missouri

August, 1997 *Supporting the Well-Being of Children in Kinship Foster Care: Research and Children's Voices Joined Together*. National Kinship Care Conference, C.W.L.A., San Francisco, California

Editorial Boards

1998-04 Appointed to Advisory Board, *Social Work in Education*

1995-99 Appointed to Advisory Board, *School Social Work Journal*.

PROFESSIONAL SOCIETIES and RELATED CERTIFICATIONS

Academy of Certified Social Workers; Association of Experiential Education; Council on Social Work Education; Illinois Association of School Social Workers; National Association of Social Workers; American Educational Research Association; Licensed Clinical Social Worker; State of Illinois, 1989 (Certified 1985); Type 73 School Social Worker Certification, State of Illinois, 1989.

Technical Assistance Coordinator:

Purpose: to plan, develop, implement, evaluate and coordinate specialized training courses; perform related work.

Principal Accountabilities: Instruction and evaluation. Typical responsibilities: determines requirements for specialized training courses; researches and assesses training needs; establishes training programs' objectives and designs appropriate courses; develops training material such as text, video, and slides with subject matter experts and develops course outlines and lesson plans; presents and evaluates training; monitors instructors and courses offered to ensure compliance with standards; may develop computer-assisted training courses or produce video instructional courses. Coordination/Administration. Typical responsibilities: oversees maintenance of training records and resource library; coordinates scheduling of training courses and facilities; coordinates agreements for development and presentation of training by subject matter experts and may coordinate instructor training seminars; may counsel individuals regarding planning and training needs; may guide/facilitate planning meetings.

Minimum Qualifications: Good knowledge of training theory.

Experience: Performing needs assessments, developing training objectives, designing and developing coursework and evaluating the training; presenting training to adult groups in structured learning situations; using a variety of training methods.

Salary Range: \$34,507 - \$53,934 Hours: 1040 per year (20 hours per week)

MARDELL C. NELSON

Idaho Department of Health & Welfare, Division of Family & Community Services

EDUCATION

1986: M.S.W. Eastern Washington University, Cheney, WA. IV-E Child Welfare Fellowship.

1971: B.S. Education, University of Idaho, Moscow, ID

LICENSES

1995-02: Certified Professional Mediator, Idaho Mediation Association.

1986-02: Certified Social Work License/Clinical Endorsement, Idaho Board Social Work Examiners.

RELEVANT EMPLOYMENT HISTORY

1995-02: Division of Family & Community Services Administrative Program Specialist. Program and resource development, training, strategic planning and quality improvement in the areas of child protection, mental health & substance abuse, developmental disabilities. Contract monitor for the Title IV-E child welfare research and training partnership with five Idaho universities.

1992-95: Division of Family & Children's Services, Child Protection/Children's Mental Health Program Specialist. Program development, clinical consultation, planning and staff training.

1989-92: Boise State University, Social Work Department, Assistant Professor /Fieldwork Director for BSW and MSW Programs. 1985-92, Adjunct Instructor

1984-89: Idaho Department of Health & Welfare, Social Work Specialist Principal. Supervised a integrated children's mental health and children protection unit, which provided intensive family assessment and brief treatment, adolescent day treatment services and child protection investigations.

1986-92: Parents United Sexual Abuse Treatment Program, Administrator. Facilitated sex offender, victim and parent groups. Conducted staff recruitment, program development, sexual abuse training and consultation.

PROFESSIONAL SERVICE/AFFILIATION

2000-02: Federal Children and Family Service Reviewer Panel, Admin. Children and Families

1997-02: Social Work Education Accreditation Site Reviewer, Council on Social Work Education

1986-96: Idaho Mediation Association, Vice-President, Certification and Standards Committee.

1988-95: Parents United International Board, Executive and Quality Assurance Committees.

COMMUNITY SERVICE

1985-93: The Sounding Board Community: Conciliation Forum, Co-founder. Provided community development, training, community needs assessment, case development and mediation services.

RESEARCH/PUBLICATIONS

2001: "Moving Toward Collaboration: Funding as a Source of Change in Child Welfare." Accepted for publication in Journal of Human Behavior in the social Environment.

1995: "Mediating Conflicts of Persons at Risk of Homelessness." Mediation Quarterly.

1990: "Speaking Out: Empowering Incest Survivors" Families in Society: The Journal of Contemporary Human Services.

1986-91: Produced "We Are Somebody", a documentary film and presentation about adult survivors of child sexual abuse. Presented at Parents United International Conferences, Norfolk, VA and San Jose, CA. Featured in the following film forums: 8th National Conference on Child Abuse and Neglect, Salt Lake City, UT; The National Symposium on Child Victimization, Atlanta, GA.; "Multi-disciplinary Responses to Child Sexual Trauma," North Carolina State Conference Raleigh, NC. Idaho Governor's Task Force on Children at Risk, "Brighter Tomorrows," Idaho Governor's Conference on Children at Risk, Boise, ID; "Empowering Families," Second Annual National Family-Based Service Conference, Boise, ID.

Communications Manager:

Purpose: To develop, maintain, and evaluate *Building on Each Other's Strengths'* information and social marketing program; serve as media spokesperson; perform related work; ensure all activities reflect the core principles of the system of care.

Principal Accountabilities: Information and social marketing planning. Typical responsibilities: establishes *Building on Each Others' Strengths'* information and social marketing goals, priorities, and operational plans; directs information and social marketing planning; establishes, revises, and implements programs, policies and procedures; develops and proposes information budget for management; monitors and evaluates *Building on Each Others' Strengths'* information and social marketing effort for value and cost-effectiveness; assesses public reaction to management policy and program decisions; consults with and advises management on media, publication, and social marketing matters; may prepare *Building on Each Others' Strengths'* position statements; develops, provides, or directs in-service information and social marketing training; hires and oversees the work of consultants, printers, and vendors such as graphic designers and photographers; coordinates development and use of displays and exhibits. Information preparation and dissemination. Typical responsibilities: coordinates *Building on Each Others' Strengths'* information flow to the public; researches background data and interviews sources to write and issue news releases and other publications; initiates and maintains a wide variety of media contacts; coordinates publicity and provides assistance at public information meetings; drafts responses and provides information to media and the public; produces or edits and coordinates the use of educational programs; makes public presentations and represents *Building on Each Others' Strengths'* at meetings and conferences; produces or edits publications such as handbooks, brochures, or newsletters through traditional paste-up methods or desktop publishing; arranges for *Building on Each Others' Strengths'* personnel to make media appearances; writes speeches, columns, and program scripts; operates audiovisual and word processing equipment; produces, edits, and determines use and distribution of audiovisual and slide presentations; maintains photo and audiovisual reference file.

Minimum Qualifications: Good knowledge of: organization, structure, and ethics of electronic or print news media. Some knowledge of: audiovisual production, to include video productions, still photography, slide shows or computer-generated graphics related to public information objectives.

Experience: planning, developing, and implementing major public information projects; developing and making oral presentations to groups; interpreting and translating technical or specialized material into information usable by the public; producing or editing informational material using electronic word processing; gathering and preparing general interest news or writing a variety of news releases that were published or broadcast in mass media for target audiences; developing, writing, and producing informational material for mass distribution and specialized audiences; overseeing contractors/vendors or supervising staff in producing publications. Skill in using specialized desktop publishing software packages is desirable.

Salary Range: \$34,507 - \$53,934

Hours: 2080 per year (40 hours per week)

Administrative Assistant:

Purpose: To perform complex secretarial, office administration, and public relations assignments; perform related work.

Distinguishing Characteristics: This classification is distinguished from the Administrative Assistant 1 by the requirement for heavy public relations role with department directors, division administrators, or comparable level executives outside the department. At this level the

Administrative Assistant 2 is expected to handle highly sensitive, confidential, and/or political issues. They are also responsible for the coordination of administrative office functions, committees, and special projects.

Nature and Scope: This position performs high level secretarial duties. Incumbent has a major role in coordinating administrative activities which requires frequent contact with executives, the public, other agencies and government officials. This requires the incumbent to utilize effective public relations and liaison skills. Incumbent may attend meetings for the project director to relay and collect information.

Incumbent functions with considerable independence and exercises discretion in applying policies and procedures. The work requires extensive knowledge of *Building On Each Other's Strengths*' programs and objectives. He/she is responsible for the research, compilation, and organization of materials for the Project Director's use in problem resolution. The position is often responsible for insuring that assignments given to other staff by the Project Director are completed and timelines are met. This position independently researches, analyzes, and compiles information to prepare reports, handle complaints, or resolve problems; compose correspondence for the Project Director on own initiative or from general instructions; format/type a variety of executive, sensitive, confidential, official and/or legal letters and documents.

Minimum Qualifications: Good knowledge of: office support functions including word processing; filing; composing a variety of business documents; reception; and researching, compiling, and summarizing data for reports.

Experience: interpreting, applying and explaining complex information such as regulations, policies or services; independently solving problems/performing liaison activities in a work setting; coordinating activities requiring complex arrangements.

Specialty Areas: Experience taking minutes; ability to type at the rate of 60 words per minute; experience using spreadsheet software; intermediate word processing skills; experience using data base software; some knowledge of supervisory practices; some knowledge of financial record keeping.

Salary Range: \$23,982 - \$37,772 Hours: 2080 hours per year (40 per week)

DONNA D. ALLINGTON

OBJECTIVE

To contribute my strong organizational skills, attention to detail, and ability to communicate effectively with others in assisting management to create a harmonious, productive workplace. To actively look for ways to improve my effectiveness in the job by applying training and computer skills.

EDUCATION

Baylor University Bachelor of Business Administration in Business Communications, Waco, TX
Beta Gamma Sigma national business honorary society; Dean's List; Tri Delta Sorority

On-going computer software classes

4 Day Workshop (28 contact hours) Meeting Facilitation Skills

Extensive training in quality assurance process by Kay Garcia

EXPERIENCE

2001 – Present ID Dept of Health & Welfare/Division of Family and Community Services

Children's Mental Health Service Delivery Project

Administrative Assistant I

Created spreadsheet to track items due to the court in response to large lawsuit

Prepare and maintain permanent files of items needed for court in development of a new service delivery system

Coordinate all meeting arrangements; responsible for meeting minutes and distribution

Monitor project budget in pre-determined Excel spreadsheet, pay bills, prepare reimbursement vouchers

Arrange travel, make reservations, and prepare travel vouchers

Order office supplies

Maintain calendar for Project Manager and schedule appointments

1998 – 2001 ID Dept of Health & Welfare/Region IV Administration

Administrative Assistant 2 Assistant to Regional Director

Participated in pilot committee project to determine regional readiness for implementing QI principles.

Introduced new agenda format for regional meetings and instructed other program secretaries in its use.

Co-chaired model committee for organizing quarterly trainings for stakeholders and staff on cross program children's issues.

Organized and led clerical support team to share information, training, and problem solving skills. This group was very successful in creating communication across programs.

Supervised two clerical positions in the Regional Director's office.

Edited confidential client files for release to attorneys and Social Security Disability Determinations.

Heavy public relations experience with complaint calls to Regional Director. Assigned staff to investigate complaint within defined timelines and prepared responses to written complaints.

Created graph representation of fingerprinting statistics in region to determine program responsibility for staffing review hearings.

Prepared agendas and minutes for twice monthly Regional Management Team meetings and twice monthly Regional Quality Improvement Team and tracked all assignments to be sure tasks were completed in a timely manner.

Maintained calendar and scheduled appointments for Regional Director
Compiled Office of Civil Rights report from information submitted by all programs in the region.

Maintained regional and departmental policy and procedures books and distributed changes to all programs.

1994 – 1998 ID Dept of Health & Welfare/Division of Health
Children's Special Health Program

Senior Secretary (Administrative Assistant I)

Prepared 80+ contracts for clinic services to CSHP clinics statewide including appendices for billing procedures and Scope of Work.

Developed data base to track expiration dates on certificates of insurance, worker's compensation insurance, and expiration dates on professional licenses. Sent letters to providers requesting updated information for files as required by state law.

Designed spreadsheet to track payments against contract amounts and prepared monthly reports from these spreadsheets.

Maintained files for each contract for required documentation and payment history

1990 – 1994 ID Division of Professional – Technical Education

Office Secretary

Prepared funding letters, reports, and grant application packets for vocational guidance pilot project and sex equity projects.

Helped plan and coordinate statewide Joint Student Leadership Conference annually; designed and organized conference packets. Helped schedule transportation for students statewide.

Edited and wrote project abstracts for final federal and state reports to Legislature.

Arranged visit schedule to school districts, notified school administrators, and arranged travel schedule.

5007 LAKES EDGE PLACE BOISE ID 83703

PHONE (208) 853-5104 E-MAIL allingtond@msn.com

SECTION H: CONFIDENTIALITY AND SAMHSA PARTICIPANT PROTECTION (SPP)

Building on Each Other's Strengths will:

Protect clients and staff from potential risk

- The collaborative process poses no additional risks that are not already part of any mental health intervention with children with SED and families. Protections already built into the Idaho MH treatment procedures will be in place for participants of this study (e.g., crises intervention available 24/7, supervisory availability, etc.). All clients will already be receiving services from some partner agency, and consents for treatment or support for that agency will already be in place. Clients and their families will become part of the collaborative process on a voluntary basis, and the consent form will clearly state the partner agencies involved and the use of client information. Potential risks can be anticipated when parent advocates and community representative become privy to private treatment information. To forestall such risks, clients and families will be the final determinants of who will be participating and at which stages of the process.
- Agency staff face potentially the same risks as clients regarding the inclusion of non-professionals in the intervention process. Specific agency proposals, staff, or interventions could be criticized depending on the results, potentially creating unsubstantiated negative

judgments within the community. To prevent this, the participatory process is designed to have the client and family set their own goals for treatment, so that individual agencies become resources for the family rather than determinants of treatment options.

- In addition to the above risk due to participation in the project, the evaluation itself may pose potential risks. Various participants will be asked to evaluate the efficiency and effectiveness of the collaborative, system of care process and to identify barriers and facilitators to collaboration. Potentially, this could include naming specific agencies or persons. To prevent exposure to such risks, process evaluation instruments will clearly state that personal names or agency names will not be used in analyzing or reporting data. Further, any data that is to be tracked by agency will be stamped confidential, will be collected by members of the evaluation team, processed into non-identifiable data and all data will be reported in the aggregate.
- Specific procedures, in addition to the above, will be used to protect participants against potential risks. Local community councils will be given training on confidentiality procedures and the extent to which even acknowledging that a specific client is a part of the process poses risks for clients. Bringing parents together for focus groups poses additional risks in addition to recognition. Experience indicates that clients often form quick bonds around commonly shared experiences during the focus group process. This can be both supportive and intrusive, as the sharing of information about their satisfaction can lead to individuals becoming aware of treatments or options that were not part of their plans but that seem on hindsight to have been a better choice. To address these issues, focus groups will be held with volunteers only and participation consent forms will clearly identify the purpose and scope of the groups and the potential risks for participants. In addition, focus groups will be held by trained members of the evaluation team only and all data collected will be publicly displayed and receive group approval before it become official focus group data.
- Project staff and evaluators will work with local community teams to help them identify signs of distress that may occur during the intervention process or evaluation thereof. Part of the consent form identifies contact persons if the participant experiences any adverse effects, including project staff and/or evaluators. Local teams will also identify support persons on an individual case basis.

Data Collection: Data will be collected from voluntary clients with SED and their families, and participating members of community councils, regional councils, and the ICCMH. For data collection procedures refer to Appendix No. 3.

Privacy and Confidentiality:

Privacy and confidentiality will be protected by:

- ensuring that all data are voluntary data;
- designing state-wide protocols determining who will collect data and how it will be collected;
- training the local and regional councils on the collection and use of identifiable (confidential) information during referral, assessment, and intervention processes;
- ensuring that all clients and families understand the potential for risks when non-professional adults are present during treatment and goal setting processes;
- ensuring that only trained team members who have signed the council charter are involved in team processes, with the exception of family advocates brought to the team by the parent (Charters will be designed by the state board to comply with existing federal and state regulations);
- storing all evaluative information on secure computers housed in the EWU School of Social Work and accessible only to evaluation team members through use of a password system;
- reporting data only in the aggregate, in non-identifiable format; and

- conforming with all Federal, State and EWU Human Subject Review Board regulations and requirements.

Obtaining Data: Data will be obtained on a voluntary basis from clients/families and system of care participants. Data will be obtained from clients/family members during clinical interviews, case management team meetings, pre-post clinical testing, pre-post client self-evaluation of progress, and voluntary follow-up surveys. Parents/community members may voluntarily participate in focus groups to collect community needs assessment data, as determined by local councils including parents.

Data will be stored in two locations according to the nature of the data:

1. Clinical and treatment (case file) data collected by service providers during interventions will be stored in the statewide FOCUS system, a secure database with access limited to DHW Program Managers or the equivalent.
2. Process evaluation data collected from individual councils and clients/families will be stored in secure computers at the Eastern Washington University School of Social Work. Only senior evaluation team members will have passwords to access the stored computer data. Stored computer data will become unidentifiable coded data upon completion of each individual case, and the code key will be kept separate from the data itself in a locked filing cabinet within a locked room to which only evaluation personnel have access.
3. Summative evaluation data will be collected on a periodic basis from the FOCUS system. Past practice has shown that data sets can be securely emailed to EWU. Over time, we would hope that a shared coding system would allow transmission of coded data, with codes be secured as described above.

Access to system of care information will initially be limited to DHW program management level persons and higher, with evaluators receiving data on a yearly or half-yearly basis. Local councils will have access only to the case file data of the cases they are currently processing. Individual cases will be secured by the lead agency or case manager during treatment, and case files will be secured following normal agency routines once FOCUS and evaluation data has been reported.

As described above, the identity of participants will be kept private by limiting access to files to the lead agency or case manager only, by reporting data only in aggregate or unidentifiable form, and by taking names off evaluation databases and using only coded numbers with the key being secured separately from the database and with access limited to senior evaluation personnel.

Consent Procedures: The following information will be included on an informed consent form and verbally explained to clients with SED and their families before they participate in the system of care program and before they are asked for their signature. This information will be made available in the child, youth or family's native language:

- Type of information requested by the system of care, including social history and other agency involvement.
- Purpose of that information
- Who will have access to the information
- Purpose of the system of care
- Members of the system of care
- What participation will look like for them
- The voluntary nature of the participation
- The right to withdraw from participation at any time, with no adverse consequences, including the right to mental health treatment
- The right to choose who they work with on the council
- The right to bring personal advocates to the council

- The right to choose which parts of the process they wish to participate in
- The potential risks and benefits to participation for the client and family
- The protections from potential risks and plans for addressing any potential adverse effects
- The right of the youth and family to participate even though they may withhold access to shared information
- The time limits of the consent
- Permission to contact other agencies

Youth, persons with limited reading or comprehension skills, and persons with limited English usage will be provided advocates/translators at their request. System of care partners will receive training in the signs or indications that youth or families do not fully comprehend the information/options being presented to them.

Signatures of the participants in the system of care will indicate that the components of the informed consent have been fully explained to them, that their questions have been answered to their satisfaction, and that they understand the options and risks inherent in the process. Consent forms will become part of the case file, and the initial staffing will begin by making sure that the client/family fully understand the form they have signed. All clients/families will receive copies of the consent form, and additional copies will be provided upon request. One comprehensive consent form will be used for the entire process. Clients/families will be informed that they may withdraw their consent at any time with no negative consequences. A sample consent form is attached in Appendix 4.

In addition to this form, a means of engaging youth in the consent process will be created. "Informed Consent" forms will be developed so that youth can indicate their willingness to engage in the process. This form will acknowledge that the parent will legally sign, but also acknowledges that the youth consents to service by the collaborative team, with the 15 points of information identified above included in the consent form as well.

Risk/Benefit Discussion: Compared to the expected benefits from this project, the risks to clients/families and staff members are reasonable. The primary risk to clients and their families is if any member of the local team breaks confidentiality and their identity becomes known. Multiple-layered steps to prevent this from occurring are included in the design of the project. No additional inherent risks that are not already part of any mental health interventions for children with SED and their families are anticipated and protections are already in place for such potentialities (e.g., crisis intervention, etc.) Clients/families may withdraw or limit participation (theirs or others) at any time during the intervention process.

The benefits for clients and their families include increasing options available to them for addressing SED needs. In particular, the voluntary nature of the program, in which clients/families become the directors of the problem solving process, means that client/families define their own level of risk at each level of service. Clients/families will feel more empowered and learn more about themselves as they become the center of goal setting and choosing activities to help them reach their goals. As the participants identify their own needs and values, service providers will increase their knowledge of how to provide individual services for clients with SED and their families. Finally, training for service providers and supervisors will promote a solution focused/results-oriented leadership model among community councils and the Regional counterparts.