ABSTRACT

The purpose of the Craighead County Connections for Kids is to build upon Craighead County's existing systems of care, to expand the range of community services available to children and families with Serious Emotional Disturbances (SED), to remove gaps and barriers to services, and to eliminate fragmentation. Connections for Kids will build upon the foundation of CASSP, corral our fragmented resources into a unified system, and alter how the "business" of serving children and families is conducted in Craighead County and ultimately across Arkansas. It will translate the promise of CASSP into a reality of daily practices and positively address the myriad of challenges in our community for the target population and those that are to help meet their needs. This collaborative effort that will begin with the Jonesboro Public School system and the juvenile justice system will demonstrate that reliance on out of home and institutional care is an unwarranted and illusory 'solution', and replace these ineffective and outdated responses with accountable best practices and evidence-based interventions for the target population.

Our children will be able to access state of the art services and supports in their daily lives: comprehensive services and supports will result from our mental health-school partnership in the development of district-wide Positive Behavioral Interventions and Supports (PBIS); supportive services and supports will avert inappropriate detention and out of home placements for children/families in the court system; and, children who are placed away from their families will be transitioned back home and served in the community. Families will finally be able to participate fully in the treatment their children receive, play a lead role in the design, development and implementation of a system grounded in best practices, and access family support and advocacy resources. Cultural disparities in access to care will be effectively addressed as we attend to long-overdue cultural inclusion, building a culturally competent SOC as a model for Arkansas. Our families will build a strong, viable and sustained family advocacy and support organization, partnering with Arkansas' Federation of Families for Children's Mental Health. The SOC in Craighead County will help children achieve their highest potential, while living in a safe and permanent home, attending local schools, maintaining and strengthening the ties between children, families, and communities. It will dramatically increase availability and quality of mental health services, establish new norms of meaningful collaboration among families, child-serving sectors and the community, as a comprehensive template for reform for Arkansas.

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BUDGET INFORMATION - Non-Construction Programs

OMB Approval No. 0348-0044

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Child Mental Hlth Init	93.104	$	$	$ 597,378.00	$ 199,126.00	$ 796,504.00
2.						0.00
3.						0.00
4.						0.00
5. Totals		$ 0.00	$ 0.00	$ 597,378.00	$ 199,126.00	$ 796,504.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total
	(1)	(2)	(3)	(4)	(5)
a. Personnel	$ 343,457.00	$	$	$	$ 343,457.00
b. Fringe Benefits	85,864.00				85,864.00
c. Travel	11,880.00				11,880.00
d. Equipment	13,914.00				13,914.00
e. Supplies	0.00				0.00
f. Contractual	328,389.00				328,389.00
g. Construction					0.00
h. Other	13,000.00				13,000.00
i. Total Direct Charges *(sum of 6a-6h)*	796,504.00	0.00	0.00	0.00	796,504.00
j. Indirect Charges					0.00
k. TOTALS *(sum of 6i and 6j)*	$ 796,504.00	$ 0.00	$ 0.00	$ 0.00	$ 796,504.00
7. Program Income	$ 0.00	$	$	$	$ 0.00

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SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8. Child Mental Health Initative	$	$ 199,126.00	$	$ 199,126.00
9.				0.00
10.				0.00
11.				0.00
12. TOTAL *(sum of lines 8-11)*	$ 0.00	$ 199,126.00	$ 0.00	$ 199,126.00

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 597,378.00	$ 136,611.00	$ 137,541.00	$ 140,122.00	$ 183,104.00
14. Non-Federal	199,126.00	45,537.00	45,847.00	46,707.00	61,035.00
15. TOTAL *(sum of lines 13 and 14)*	$ 796,504.00	$ 182,148.00	$ 183,388.00	$ 186,829.00	$ 244,139.00

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (Years)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16. Child Mental Health Initative	$ 1,171,879.00	$ 1,642,576.00	$ 1,406,491.00	$ 1,136,293.00
17.				
18.				
19.				
20. TOTAL *(sum of lines 16-19)*	$ 1,171,879.00	$ 1,642,576.00	$ 1,406,491.00	$ 1,136,293.00

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:	22. Indirect Charges: No Fed Approved Indirect Cost Rate currently, We hope to have one future years
23. Remarks:	

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Mid-South Health Systems
Detailed Budget

Craighead County Community Connections

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Personnel						
Total Salaries (See Personnel Listing)	**$343,457**	**$789,780**	**$1,213,497**	**$1,645,155**	**$2,090,165**	**$1,809,686**
Fringe Benefits @ 25%	**$ 85,864**	**$ 197,445**	**$ 303,374**	**$ 411,289**	**$ 522,541**	**$ 452,422**
Travel - Mileage Reimbursement						
Case Manager Travel @1196 miles/mo/@.23/mile = $3,301/CM		$ 26,400	$ 52,800	$ 79,200	$ 105,600	$ 92,400
MHP Mileage Reimb @ 326 miles/mo@.23/mile		$ 3,600	$ 7,200	$ 10,800	$ 14,400	$ 12,600
Total Travel - Mileage Reimbursement	**$ -**	**$ 30,000**	**$ 60,000**	**$ 90,000**	**$ 120,000**	**$ 105,000**
Contractual						
Evaluation Contract						
Personnel Salaries						
Post Doctoral Fellow Position - TBH	$ 40,000	$ 41,200	$ 42,436	$ 43,709	$ 45,020	$ 46,371
David Saarnio, PhD 25%	20,444	21,057	21,689	22,340	23,010	23,700
Aaron Bolin, PhD 25%	13,737	14,149	14,574	15,011	15,461	15,925
Lisa A. Ochs, PhD 10%	4,257	4,385	4,516	4,652	4,791	4,935
Christy Brinkley, Ed.S. 40%	16,800	17,304	17,823	18,358	18,909	19,476
Parent Evaluator - TBH 100%	12,000	12,360	12,731	13,113	13,506	13,911
Total Evaluation Personnel Salaries	$ 107,238	$ 110,455	$ 113,769	$ 117,182	$ 120,697	$ 124,318
Fringe Benefits (28.3%)	$ 30,348	$ 31,259	$ 32,197	$ 33,162	$ 34,157	$ 35,182
Total Salaries and Fringe	$ 137,586	$ 141,714	$ 145,965	$ 150,344	$ 154,855	$ 159,500
Office Space (a 10'x10' office & a 5'x10' office @ 10.21/sqft	1,532	1,532	1,532	1,532	1,532	1,532
Equipment Dell Latitude D800 1.7 gh						
Laptop PC	2,319		2,319			
Local Travel						
Travel for conferences	3,000	3,000	3,000	3,000	3,000	3,000
Supplies						
Supplies to support the program which include paper, testing materials, computer disks, file folders,clinical copyrighted instruments, etc.	7,000	5,000	5,000	5,000	5,000	5,000
Total Evaluation Component Contractual	$ 151,437	$ 151,245	$ 157,816	$ 159,876	$ 164,386	$ 169,032
PBIS Component						
Salaries						
Coordinator - Marylin Copeland	12,500	51,500	53,045	54,636	56,275	57,964
Total PBIS Salaries	12,500	51,500	53,045	54,636	56,275	57,964
Fringe Benefits	3,125	12,875	13,261	13,659	14,069	14,491
Substitute Teachers		4,500	4,500	4,500	4,500	7,200
PBIS Coach Training (10 days training)	10,000					
Travel		8,000	8,000	8,000	8,000	8,000
Supplies		4,500	4,500	4,500	4,500	4,500
PBIS Consultant, Lucile Eber, 12 Days per year	10,000	10,000	10,000	10,000	10,000	10,000
Consultant Travel	6,000	6,000	6,000	6,000	6,000	6,000
Total PBIS Component Costs	**41,625**	**97,375**	**99,306**	**101,295**	**103,344**	**108,155**
ASU Social Work Department						
Connie Ryan (50%of Salary and Fringe @33.13%)	26,739	27,809	28,921	30,078	31,281	
Trish Holt (50% of Salary & Fringe @27.4%)	25,588	26,612	27,676	28,783	29,935	
Total ASU Social Work Department	**52,327**	**54,421**	**56,597**	**58,861**	**61,216**	**0**

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Red Point						
Red Point Software		22,000	16,000	16,000	0	
Red Point Services		22,000	27,000	35,000	27,000	
Servers		11,000	10,000	8,000	0	
Photo System		25,500	20,400	10,200		
Remote Attendance System		9,000	6,000	6,000	0	
Supplies (Cards & Ribbons		2,820	5,076	7,332	7,332	
Lunch Room		9,000	4,800	3,600		
Travel, Taxes & Freight on Systems		5,000	5,000	5,000	5,000	
Total Red Point System	**0**	**106,320**	**94,276**	**91,132**	**39,332**	**0**
Key consultants						
Family Consultant - Pam Marshall (1 day per Mo @ $833 including expenses)	10,000	10,000	10,000	10,000	10,000	10,000
Mental Health Consultant - Marty Hydecker 4 3day visits @ $833)	10,000	10,000	10,000	10,000	10,000	10,000
2 Family Consultants @ $10,000/Year	20,000	20,000	20,000	20,000	20,000	20,000
Cultural Compentency Consultant James Mason 3 visits @ $4,000	12,000	12,000	12,000	12,000	12,000	12,000
Arkansas Federation of Families for Children's Mental Health: Develop a Craighead County Chapter/mo meetings; Provide Qtrly training session for families and other Stakeholders; Support attendance to National Federation conference; Provide Advocacy traini	25,000					
Consultant Travel	6,000	6,000	6,000	6,000	6,000	6,000
Total Contractual	**$ 328,389**	**$ 467,361**	**$ 465,995**	**$ 469,165**	**$ 426,278**	**$ 335,186**
M&O						
Professional Liability	0	2,020	5,040	7,560	10,080	12,600
Total M&O	**0**	**2,020**	**5,040**	**7,560**	**10,080**	**12,600**
Equipment						
Dell Latitude D800 Laptops, 1 per MHP & 1 per 4 CaseManagers @ $2,319 each	$ 13,914		$ 13,914	$ 13,914	$ 13,914	
Total Equipment	**$ 13,914**	**$ -**	**$ 13,914**	**$ 13,914**	**$ 13,914**	**$ -**
Training						
SAMHSA Conference: 3 required 3 night for 10 staff ($500 airfare, $80 hotel(dbl. occ.) $70/meals/day)	$ 9,500	$ 9,500	$ 9,500	$ 9,500	$ 9,500	$ 9,500
Systems of Care Conference, (2 staff @ $1,190 (4 days 3 nights, Air Fare $500, Hotel $150/night, Meals)$60/day)	2,380		2,380			
Total Training	**$ 11,880**	**$ 9,500**	**$ 11,880**	**$ 9,500**	**$ 9,500**	**$ 9,500**
Social Marketing						
Brochures	2,000					
Supplies & Promotional Items for teachers, Juvenile Justice workers & social services workers	5,000	2,000	2,000	2,000	2,000	
Newspaper Advertising: 1/2 page ad announcing The CCC Connections	2,400					
Television advertising in 4th qtr Year one and monthly Year 2 (264 spots monthly on 4 cable stations each month)	3,600	14,400	14,400	14,400	14,400	
Total Social Marketing	**13,000**	**16,400**	**16,400**	**16,400**	**16,400**	**0**
Flexible Funds						
Wraparound		50,000	100,000	150,000	200,000	200,000
Total Flexible Funds	**0**	**50,000**	**100,000**	**150,000**	**200,000**	**200,000**
Total Direct Expenditures	**$ 796,504**	**$ 1,562,506**	**$ 2,190,101**	**$ 2,812,982**	**$ 3,408,878**	**$ 2,924,394**

Mid-South Health Systems
Craighead County Community Connections
Personnel

Title	Base Salary	% FTE	Salary from PDV	Hired in Yr	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Bonnie White Principal Investigator	$133,673	0.2	$26,735	1	$ 26,735	$ 27,537	$ 28,363	$ 29,214	$ 30,090	$ 30,993
Alice Baugh Project Director	$60,000	1	$60,000	1	60,000	61,800	63,654	65,564	67,531	69,557
TBH	$25,000	1	$25,000	1	25,000	25,750	26,523	27,319	28,139	28,983
Clinical Director - Sharon Travis	$57,368	0.5	$28,684	1	28,684	29,544	30,431	31,344	32,284	33,253
TBH	$25,000	1	$25,000	1	25,000	25,750	26,523	27,319	28,139	28,983
Lewis	$25,000	1	$25,000	1	25,000	25,750	26,523	27,319	28,139	28,983
Youth Coordinator TBH	$25,000	1	$25,000	1	25,000	25,750	26,523	27,319	28,139	28,983
Crisis Response Coordinator	$45,000	1	$45,000	1	45,000	46,350	47,741	49,173	50,648	52,167
Tech Assistant - Derrick Spiegel	$48,000	0.5	$24,000	1	24,000	24,720	25,462	26,226	27,013	27,823
Social Marketing Matt Knight (25% y 1-5)	$44,216	0.25	$11,054	1	11,054	11,386	11,727	12,079	12,441	
Social Marketing Jayni Blackburn (25% y 1-5)	61267	0.25	$15,317	1	15,317	15,776	16,250	16,738	17,240	
State and Local Agency Liaison - Anne Wells 25% Y 2-6	$60,000	0.25	$15,000	2		15,000	15,450	15,914	16,391	16,883
Red Point Tech	$30,000	1	$30,000	2		30,000	30,900	31,827	32,782	
Case Manager - TBH start in Mo 12 Y 1	$28,000	8	$224,000	1	18,667	224,000	230,720	237,642	244,771	
Case Manager - TBH start in Mo 12 Y 2	$28,000	8	$224,000	2		18,667	224,000	230,720	237,642	244,771
Case Manager - TBH start in Mo 12 Y 3	$28,000	8	$224,000	3			18,667	224,000	230,720	237,642
Case Manager - TBH start in Mo 12 Y 4	$28,000	8	$224,000	4				18,667	224,000	230,720
Case Manager - TBH start in Mo 12 Y 5	$28,000	4	$112,000	5					18,667	112,000
Case Manger	$28,000		$0	6						0
Therapist	$42,000	4	$168,000	1	14,000	168,000	173,040	178,231	183,578	
Therapist	$42,000	4	$168,000	2		14,000	168,000	173,040	178,231	183,578
Therapist	$42,000	4	$168,000	3			14,000	168,000	173,040	178,231
Therapist	$42,000	4	$168,000	4				14,000	168,000	173,040
Therapist	$42,000	2	$84,000	5					14,000	84,000
Therapist	$42,000		$0	6						0
Clerical - TBH (50% y 3; 75% y 4; 100% y 5-6)	$18,000	1	$18,000	3			9,000	13,500	18,540	19,096
Clerical	$18,000		$0						0	0
		1	$0			0	0	0	0	0
Total Salaries					$343,456	$789,780	$1,213,497	$1,645,155	$2,090,165	$1,809,686

Alice Baugh

PROGRAM NARRATIVE

SECTION A: UNDERSTANDING OF THE CRAIGHEAD CONNECTIONS FOR CHILDREN PROJECT

On March 24 1998, two elementary school students, ages 9 and 11, opened fire on their classmates and teachers, killing five people in Jonesboro, Arkansas. One student pulled the fire alarm in order to get everyone outside, then ran to meet the second student who was waiting in a wooded area with guns and ammunition stolen from his grandfather. These students had caring families, no history of major discipline problems at school, and were unknown to the local juvenile justice and mental health systems. A mental health therapist from Mid-South Health Systems was on campus that day, as she had been on many preceding days. Our small community was smug in its belief that such tragedies occurred only in "big cities." We would have boasted to you about our "System of Care" and the good job we were doing to help youngsters and their families. Yet, we failed that day.

That tragedy led us to take a look at Jonesboro and to examine the strengths and weaknesses in Craighead County, Arkansas. Jonesboro is a small, quasi-rural town that has about 55,000 people. The population of the city has grown rapidly, but this growth is not reflected in the rest of the county. Other than Arkansas State University and the medical community, most of the people either work in factories or in agriculture. Craighead County lies in the Mississippi Delta. Like other Delta counties, Craighead has widespread poverty, although it does have pockets of affluence, leading to a great deal of unevenness in school systems, services, etc. We are the regional center for Northeast Arkansas and Southeast Missouri, and provide services for over 200,000 people. We are adjacent to Missouri, and in particular the boot-heel of Missouri, which has the highest methamphetimine productions in the nation. Northeast Arkansas suffers many of the consequences of the production and use of methamphetamine, and Craighead County attracts both manufacturers and users. We have high teen pregnancy rates (among the highest in the nation). Over 35% of children born in Arkansas are born to single mothers. We have a relatively unhealthy population, with significant heart disease (again, some of the highest in the nation) and inactive lifestyles.

We recognize we need to do more, and believe that the implementation of a comprehensive and sustainable System of Care (the Craighead County Connections for Kids) is the only viable next step. The future of Craighead County, Arkansas, and America depends on our children and their families. An initial response to the shooting incident in our community was a collaborative Safe Schools/Healthy students grant involving numerous community players. Though this served as an impetus to unite our community and initiate many collaborative relationship, in 2003 we continue to face fragmentation of services, lack of information, poor communication, and children and their families continue to 'fall through the cracks' of our human services system. We believe that the help, hope and power needed to raise healthy children must be found first in the strengths of families and communities. However, far too many of our children have Serious Emotional Disturbances (SED) that interfere with normal development and functioning in many aspects of their daily lives—at home, in school, in social situations, and in the community. These challenges often require services and supports that cross traditional agency and organizational boundaries. The driving force for developing a System of Care (SOC) stems from understanding the impact of SED on the lives of children, youth, and their families, how they are dependent upon and must negotiate with a complicated and fragmented service delivery system at a time when they are often most vulnerable (Osher, deFur, Nava, et al., 1999). This frequently leads to crises, over use of restrictive and costly residential, inpatient and other out-of-community services, separating children from their families and communities and causing further problems. For families who have children with SED, it takes the collaborative efforts of the family and the community's wisest helpers, paid and volunteer, to provide coordinated services and supports within an integrated system to assure that children reach their full potential. Across the county there is a growing call from families of these children and youth– the primary experts on the

strengths and needs of their children, and the predominant stakeholders for meaningful reform for the development of home and community-based System of Care (SOC) as a solution. A SOC is defined as a comprehensive spectrum of mental health and other support services, which are organized into a coordinated network to meet the multiple and changing needs of children/youth with SED and their families. There is also a growing awareness among the child-and family-services sectors that traditional service approaches are not working, that they are serving many of the same children and families, and that by working together, the community can build an effective service delivery system on behalf of these children and families.

Emerging results of SOC implementation come from the experiences of affected families and from multiple evaluations (Center for Mental Health Services, 1999; Burns & Hoagwood, 2002). This research indicates that expanding the array of community-based services and supports well beyond traditional services for children with mental health needs, and their families, enables these youngsters to remain in the home, be successful in school, and participate in their communities. These outcomes produce meaningful improvements in the lives of children and their families, preventing costly and largely ineffective out of home placements; and result from committed application of a set of core SOC values and principles (Stroul & Friedman, 1986) that operate in everyday practices, at the community program level, and at the system/policy level:

Core Values – Systems of Care are:

- Child-centered, family focused, and family driven;
- Community-based; and
- Culturally competent and responsive.

Principles – In Systems of Care, children/youth and their families should:

- Have access to a comprehensive array of services that address the child's physical, emotional, social, and educational needs;
- Receive individualized services in accordance with the unique needs and potential of each child/youth and guided by an individualized service plan;
- Receive services within the least restrictive, most normative environment that is clinically appropriate;
- Receive services that are integrated, with linkages among child-caring agencies and programs, and mechanisms for planning, developing and coordinating services;
- Be provided with care management or a similar mechanism to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children/youth can move through the system of services in accordance with their changing needs;
- Be able to participate in family/professional partnerships in all aspects of planning, implementation, delivery, management, and evaluation of the service delivery system responsible for serving their children;
- Be provided with early identification and intervention by the SOC in order to enhance the likelihood of positive outcomes;
- Be ensured of a smooth transition to adulthood and to the adult service system;
- Have their rights protected and effective advocacy efforts promoted;
- Receive culturally competent/appropriate services, which are sensitive and responsive to culture and gender differences and special needs, and are provided without regard to race, religion, nation origin, sex, physical disability, sexual orientation, or other characteristics.

A SOC requires that these values and principles permeate all aspects of its development and implementation (CMHS, 2003): 1)The mental health service system is driven by the needs and preferences of the child and family, using a strengths-based perspective. Services are planned, delivered and monitored through individualized Care Teams. The family's strengths and needs, as well as cultural resources and differences, are reflected in the membership of the team and in the individualized plan. Just as no two families are alike, no two Care Teams or individualized plans are alike in the SOC. 2) Family involvement is integrated into all aspects of service planning and delivery. Family Centered practice is a core element of SOC implementation, acknowledging that families are the experts on what they need. Child and family ownership of their plans helps build upon the strengths of each member of the family, alleviate distress, and respond to real life needs. 3) The locus and management of services are built on multi-agency

collaboration and grounded in a strong community base. Often, families of children with SED become isolated. Informal community connections provide sources of enduring support and help families re-engage with their neighborhoods and communities. Agencies working together in community-based teams help ensure access to their services, educate each other about entitlements and service gaps, and help promote a unified and comprehensive service array that links formal and informal resources. 4) A broad array of services and supports are provided in an individualized, flexible, coordinated manner and emphasize treatment in the least restrictive, most appropriate setting. Care Teams work with children/families to develop comprehensive plans using wraparound approaches and life domains in the SOC. Life domain areas represent the needs of all families, e.g., financial, health, safety, spiritual, cultural, social, etc. Working with families around these domains helps professionals move away from limited 'service solutions', helps families build resilience and obtain the formal and informal resources they need to succeed. Community-based services and supports help families develop closer ties to 'non-professional' supports and maintain closer ties between children and their families. 5) The services offered, the agencies participating, and the programs generated are responsive to the cultural context and characteristics of the populations that are served. The selection, mix and design of services and supports, as well as the infrastructures that must support the SOC become far more responsive to the 'real' needs of families when families who represent the true cultural richness of the community are full partners.

There is a direct and powerful relationship between family capacity and culturally determined measures of success in the service seeking and service delivery process. In order for supports and services to be functionally effective for families, they must be culturally acceptable. There is growing awareness of the implications of cultural difference for service delivery. Differences among cultural and ethnic groups speak to the need for services that are provided in a culturally competent manner (Lecca, Quervalu, Nunes, et al., 1998). Culture impacts how family members express and cope with mental health distress, and their help-seeking behaviors. Families representing racial and ethnic minorities may not seek mental health services because of costs, limited availability of service and lack of availability of providers of like-culture. In fact, members of ethnic and cultural minorities often mistrust mental health providers, and there is evidence of clinical bias and stereotyping by providers (Surgeon General Report, 2001). Harry (1992) found that when family members do not trust service providers, they are likely to withdraw from participation, and service providers may interpret their behavior as a sign of apathy. However, they are more likely to value partnerships with service providers that honor and respect differences among families, and reflect shared power and responsibility in their relationships with families (DeChillo et al., 1994; Roberts, Rule, & Innocenti, 1998). According to the Child Welfare League of America (2001), race is a powerful predictor of mental health outcomes, e.g., even when presenting the same behaviors, white middle-class children are more likely to access health and mental health services, while children who are African American and from lower economic brackets are often placed in juvenile justice systems. Additionally, youth who are African American tend to be referred more often for behavior problems than for earlier underlying warning signs, which often go undiagnosed and untreated.

As is the case throughout the systems reform, family members play a key role in this challenging area - the rich experience and diversity that they bring to the effort is fundamental to the successful development and delivery of culturally responsive care Strengths, cultures, preferences and values of families become reflected in training, staffing patterns, service arrays and routine practice when SOC values and practices are actualized. In fact, the development and implementation of SOC cannot be realized without full, sustained involvement of diverse families receiving services from the community and of the target population. According to the Federation of Families for Children's Mental Health (Adams, Biss, et.al.1997), this requires a basic appreciation that families are already fundamental participants in the "ecosystem that raises and serves children". Family involvement necessitates respect for the essential role families have in the life of their children, and therefore, their role as vital members of the 'system'. The values and principles upon which SOC is based can only be realized through inclusion of these families

as fully involved partners from the beginning, so that their experiences and perspectives collectively drive the planning, implementation, and evaluation of the SOC.

The history of SOC development in the United States spans across the past three decades, as increasing attention has been given to the needs of youngsters with SED and their families. A series of key findings, events and opportunities have shaped the emergence of SOC: The 1968 Joint Commission on Mental Health of Children cited services for children with mental illnesses were fragmented, overly-restrictive, services were most often through out-of home placements in state hospitals (Joint Commission, 1968). The 1978 Carter Commission recommended a network of services be developed in communities for children with SED may be better served. In 1982, the National Institutes of Mental Health (NIMH) and State Mental Health Representatives for Children and Youth (SMHRCY) defined populations of children with SED, provided guidelines on types of services needed, how a "continuum of care" should be constructed to include a variety of agencies, and promoted advocacy. efforts among the families affected by SED. The publication of Jane Knitzer's *Unclaimed Children* (1982), galvanizing advocates and other leaders to take action on the deplorable state of affairs for children with SED and their families; Federal leadership, along with a growing family movement, began to create a new paradigm for serving the estimated 4.5 to 6.3 million children in the United States who have a SED (Friedman, Katz-Leavy, et. al., 1999). The landscape of services for this population began to change in 1984 when the Congress responded to the call for change and funded the Child and Adolescent Service System Program (CASSP). The CASSP movement began to revamp the system, creating structures for "coordinated policy development", "comprehensive planning", and state grants dedicated to transform child mental health service systems. CASSP heralded "wraparound" approaches, championed child-centered, family driven concepts, putting families back in the drivers' seats in meeting the needs of their children. This was the beginning of a different mindset that promoted interagency efforts to improve systems and services for children and youth with SED and their families.

The emergence of the national 'family movement' is an overarching influence in the history of SOC, resulting in a stronger voice for families raising children with mental health needs, including SED. Historically, many professionals believed that families were just as troubled, if not more troubled, than their children; they were often viewed as 'dysfunctional', 'resistant', and the root 'cause' of the problems. Rarely were parents involved in treatment planning for their children, beyond questioning them about abuse, substance abuse, marital problems or the need for parent training. (Osher, deFur, Nava, et al., 1999). Families struggled to gain a voice in the care of their children and as respected experts in their own right to shape and hold accountable the emerging SOC as a viable solution for their children and for the systems that were to help meet their needs. Through this struggle, family leadership was became recognized as essential to SOC. A national family-run organization established in 1989, the Federation of Families for Children's Mental Health, created a platform for these families in state and national policy arenas, and new models of family involvement began to emerge. The struggle for meaningful family involvement continues to this day, but families across the country have already played a significant role in mental health reform, and are key partners in nationwide SOC development.

These collective efforts have resulted in a now widely recognized SOC approach, designed to help build comprehensive service systems that allow children with emotional disturbance to receive a comprehensive array of integrated, community-based services. The SOC approach is based on a philosophy built on three hallmark tenets: (a) mental health service systems are driven by the needs and preferences of the child, youth, and family; (b) services and supports are community based with their management built on multi-agency and community collaborations; and (c) the services/supports offered, the agencies participating, and the programs generated to meet the mental health needs of the children are responsive to the cultural context and other characteristics of the children, youth and families being served. To develop a SOC consistent with this theoretical approach, a community must ensure (a) a collaborative infrastructure to house, organize, and manage an organized service support system emphasizing comprehensive and individualized, culturally competent/appropriate services provided in the least restrictive environment, the full involvement of families, public/private interagency collaboration at the

program and system level; and, (b) a full array of necessary services, treatments, and supports, delivered through care coordination and offered directly to children and families. The Center for Mental Health Services (CMHS) within the Substance Abuse and Mental Health Services Administration (SAMHSA) has primary responsibility for translating this framework into a services and supports around the country with the passage of the Children's and Communities Mental Health Services Improvement Act in 1992. CMHS has championed the development of SOC through its Comprehensive Community Mental Health Services for Children and Their Families Program; this program, now in its sixth year, provides grants to States, communities, territories, American Indian tribes, and Alaskan Native communities to develop SOC to meet the needs of children and adolescents with SED and their families. Funding for the initiative has grown to $78 million. CMHS is mandated by Congress to demonstrate the effectiveness of these systems through a National Evaluation that tracks outcomes and progress. The results help guide current grant communities and sets a benchmark for future generations of community-based SOC. (CMHS, 1999). Other SOC demonstrations across the country have grown out of this initiative, such as those from the Title V Children with Special Health Needs Program and foundation-supported efforts, e.g., Annie E. Casey Foundation and The Robert Wood Johnson Foundation's Mental Health Services Program for Youth Project. All these initiatives are based on SOC values and principles, promoting home- and community-based alternatives to juvenile justice, hospital and institutional settings. The national Federation of Families for Children's Mental Health and its Statewide Organizations have and continue to be a principal partner with virtually all of these funders, helping to ensure the voice and full involvement of families in SOC development and implementation.

The **need for systems-of-care reform in the United States** is urgent and compelling. This national concern is supported by the Surgeons General's (1999) report on mental health suggesting there are between 6-9 million children in the United States with SED, many of whom have co-occurring disorders that require collaborative efforts from public service systems. A 1999 National Institute of Mental Health study (Childnotes, 2003), estimated that almost 21 % of U.S. children ages 9 - 17 had a diagnosable mental or addictive disorder that resulted in some impairment in daily functioning. Nine to thirteen percent have SED with substantial functional impairment, and 5-9% of youth with SED have extreme functional impairment; however, it is estimated that fewer than one in five of these youth receives needed treatment in any given year.

The report from the Surgeon General's Conference on Children's Mental Health (2000) decries the suffering of children and their families resulting from "missed opportunities for prevention and early identification, fragmented services, and low priorities for resources", compounded by the stigma that "continues to surround mental illness", yet (NIMH, Childnotes, 2003) fewer than one in five receives needed treatment in a given year. The World Health Organization (2002) warns that "by the year 2020, child and adolescent emotional and behavioral disorders could rise proportionately by fifty percent throughout the world to become one of the five most common causes of death, illness and disability among children". There is a long history of placing such children in institutional care away from their homes and communities to obtain intensive and ongoing treatment and/or to ensure safety for the child, family and the public, despite evidence of negative outcomes for youth, disruption of families, and high financial costs (Burns & Hoagwood, 2002). The NY Times ("Mental Care Poor for Some Children in State Custody", 2003) reported that thousands of parents across America, desperate for mental health treatment for their children, continue to send their children to foster homes, state mental hospitals, juvenile jails and other institutions because they cannot access needed services in their homes, schools and communities. The Government Accounting Office (2003) just released a report describing the plight of families forced into making the devastating decision to relinquish custody of their children to obtain essential treatment, and attributes this appalling situation to lack of coordination, inadequate mental health coverage and resources. In fact, children and youth with SED "have the civil right to receive services in the most integrated setting appropriate to their needs" (Olmstead v.L.C., 1999) and the "human right to be raised in their families and communities, with their individual needs guiding the service array provided" (Bazelon Center for Mental Health Law, 2001). The national Federation of Families for

Children's Mental Health, cites the failure to provide necessary and appropriate services and supports to these children and their families are "devastating and wasteful", noting that over half (55%) of all students with emotional disturbance do not finish high school and, of those, almost three quarters are arrested within five years of leaving school (FFCMH, 2002). These practices persist despite the investigation and validation (also described as empirically supported, or evidence based) of a number of promising treatment approaches including therapies for internalizing (e.g., anxiety and depression), externalizing (e.g., oppositional and antisocial behavior), and other (e.g., autism) types of disorders (Kazdin & Weisz, 1998). Our children and their families continue to bear tremendous burdens associated with mental illness (National Advisory Mental Health Council's Workgroup, 2001).

When schools, child welfare, and the larger mental health structures fail to meet the mental health needs of children, the consequences are often tragic The juvenile justice system is rapidly emerging as the "default" structure of treatment for many youth, including those with co-occurring mental health and substance abuse and disorders. The Justice for Juveniles Report (Cocozza, Stainbrook, et. al., 1999) notes that 50-75% of youth in detention have mental health needs; at least half had symptoms of clinical depression, conduct disorders and co-occurring substance abuse and mental health disorders; and, slightly less than half were diagnosed with Attention Deficit Hyperactivity Disorder. Though data is still emerging, there is growing recognition that some youth begin to use drugs and/or alcohol as a way to self-medicate the symptoms of mental health problems such as depression or anxiety. (Blamed and Ashamed, 2002). Children already being served by such systems as child welfare and juvenile justice are particularly vulnerable to psychosocial stressors and in the greatest need of care. Yet, they have difficulty accessing to care, receiving proper diagnoses, experience stigma associated with mental health treatment, and for some, racial disparities. Since families of different cultural and socio-economic circumstances may have different value judgments about what is normal behavior, they may be reluctant to seek mental health treatment for fear of stigma and blame, often finding that race can be a powerful predictor of mental health outcomes. For example, children from white, middle-class environments more often access health and mental health services, while those who are African American tend to be 'tracked' into juvenile justice systems even when presenting similar behaviors (Child Welfare League of America, 2001). Our country's school systems are struggling to "Leave No Child Behind", and many are seeking new collaborations (such as Positive Behavioral Interventions and Supports) to address neighborhood, family, peer and community challenges that impact academic achievement (Mental Health in Schools, UCLA, 2002). The mental health needs of children in the child welfare system are also of great concern, with an estimated 250,000 or more youth who need mental health services now in foster care (Burns & Hoagwood, 2002), many of whom experience multiple placements and ongoing separation from their homes, schools and community.

Similarly, there is great **need for state and local service system reform** for children with SED and their families in Arkansas and **in Craighead County**. Problems in the Arkansas Children's Mental Health System are rooted in systemic deficits. Agencies across the state do not have effective systemic approaches that are coordinated and collaborative, hindering planning, development, funding and oversight of mental health services. And, many children with SED are still ushered into out-of-home placements through foster homes, detention centers, and inpatient facilities. The State took action to address these problems through legislation (Act 964) in 1991 establishing the Child and Adolescent Service System Program (CASSP) to coordinate policy development and comprehensive planning. This mandate called for CASSP to build on existing resources, design and implement a coordinated system of services that is child and family centered and community based. This legislation included a funding appropriation request that was not granted. Act 1517 of 2001 updated and support the CASSP system. Unfortunately, SOC strategies to include coordination among Department of Children and Family Services, inclusion public, private, and other stakeholders, and creation of an interagency service plan did not increase responsibility and accountability as intended. Furthermore, Arkansas' Medicaid policy was changed to allow "any willing provider" to offer mental health services. These agencies have been allowed to operate independently with no requirements or incentives to work with the

child-serving public sector as part of one unified system. The number of private providers has increased exponentially, further fragmenting the fragile network of public services and leading to uncontrolled Medicaid expenditures. In Craighead County, new providers enlist Medicaid eligible families, yet send individuals without a source of reimbursement to the public sector.

Inpatient expenditures have risen to an all time high statewide. Costs for mental health services continue to soar, with Medicaid dollars almost doubling from 1997 to 2002 for the 0-21 age group. In the 2002 Biennium, the Legislature considered reducing mental health services in Arkansas due to exorbitant costs of care. Even basic services such as outpatient and family therapy are now provided on a marginal basis compared to the need, and significant gaps in other services were identified statewide by the CASSP Coordinating Council 2002 including: Early intervention and prevention services; services for preschool children; services for children/youth with co-occurring substance abuse and mental health needs, developmentally disabled with mental health concerns; sex offender treatment; day treatment; home and school-based services; and respite services. In the target community of Craighead County, respite care and independent living services are unavailable; home-based services are available on a very limited basis and are not meeting current need; substance abuse services are available on a very limited basis. Children with SED and their families are not receiving adequate community-based services and supports, resulting in unacceptably high rates of out of home placements, juvenile justice involvement and incarceration, unidentified and untreated substance abuse, and relinquishment of custody. The local child welfare office reports 123 youth in foster care in Craighead County during last fiscal year. These youth are now "wards of the State" , under the jurisdiction of a local judge who will make decisions regarding the youth's return to their home, placement elsewhere, or termination of parental rights. A strong, coordinated SOC should provide the services and supports needed to allow for family reunification, rather than the dissolution of the family unit, which often occurs. Our local juvenile justice system deals with over 1200 violations per year. Almost 10% of these young people are hospitalized or sent to residential treatment because there is not a process in place to keep them in their homes and communities, keep the youth and the community safe while working with the families to bring about positive change.

Other key factors that prevent coordinated service delivery include lack of planning, funding constraints and human resource issues. For example, children seen by private providers often have their services discontinued, are left on their own or referred to the community mental health center, making treatment disjointed and fragmented. There is a lack of coordination across services, and funding constraints lead children to be passed around in a revolving service door. Families in Craighead County have identified a number of key concerns that call for system reform in our community: service access delays, fragmentation in services with public and private providers, lack of positive relationships with providers, lack of information on treatment and child development, lack of professional education on best practices, lack of accountability built into systems, lack of parent training on systems structures, lack of family to family support and training, serious gaps in services such as respite and in-home.

The **significance of developing SOC in the target area** cannot be overstated. Craighead County's Connections for Kids will build upon the foundation of CASSP, corral our fragmented resources into a unified system, and alter how the "business" of serving children and families is conducted here and ultimately across Arkansas. It will translate the promise of CASSP into a reality of daily practices, positively address the myriad of challenges in our community for the target population and those that are to help meet their needs. It will improve the child serving systems ability to access services from each other, help unify separate, overlapping systems offering parallel, sequential and/or duplicative services. There are any number of strong individual programs and providers that deliver excellent services, but operate outside a coordinated network of care; these resources will be integrated through a collaborative leadership and governance structure, through unified/individualized Care Teams and Plans. Fragmented funding, conflicting funding priorities and collaboration disincentives will be transformed by policies and practices that encourage braided funding and effective use of Flexible Funds. While present funding does not match level of need, better coordination between existing funding sources through SOC will begin to close that gap. Specifically, this collaborative effort that will

begin with the Craighead Public School system and the juvenile justice system will demonstrate that reliance on out of home and institutional care is an unwarranted and illusory 'solution', and replace these ineffective, outdated responses with accountable best practices and evidence-based interventions for the target population. Services will be accessible and build on family and community strengths. Our children will be able to access state of the art services and supports in their daily lives: comprehensive services and supports through our mental health-school partnership in the development of district-wide Positive Behavioral Interventions and Supports (PBIS); services and supports will avert inappropriate detention and out of home placements for children/families in the court system; children who are placed away from their families will be transitioned back home and served in the community. Families will finally be able to participate fully in the treatment their children receive, play a lead role in the design, development and implementation of services and a system grounded in best practices, and access family support and advocacy resources. Cultural disparities in access to care will be effectively addressed as we attend to long-overdue cultural inclusion, building a culturally competent SOC as a model for Arkansas. Our families will build a strong, viable and sustainable family advocacy and support organization, partnering with Arkansas' Federation of Families for Children's Mental Health. The SOC in Craighead County will help children achieve their highest potential, while living in a safe and permanent home, attending local schools, maintaining and strengthening the ties between children, families, and community. It will dramatically increase availability and quality of mental health services, establish new norms of meaningful collaboration among families, child-serving sectors and the community as a comprehensive template for reform for Arkansas.

TARGET POPULATION

The **target population** for Connections for Kids is children and youth:

1) Ages 5 to 18, as well as those who are between 18 and 21 when enrolled in the project prior to age 18; and,
2) Who have an emotional, behavioral, or mental disorder under DSM-IV or its ICD-9-CM equivalents, or subsequent revisions, including those with a co-occurring SED and Substance Use Disorder (SUD); and,
3) Who have a disability that must have been present for at least one year, or, on the basis of diagnosis, severity, or multi-agency intervention, be expected to last more than one year; and,
4) Who are unable to function in the family, school, or community, or in a combination of these settings as measured by a total score of 140 on the Child and Adolescent Functional Assessment Scale (CAFAS); OR whose level of functioning is such that the child/youth requires multi-agency intervention involving two or more community service agencies providing services in the areas of mental health, education, child welfare, juvenile justice, substance abuse, and primary health care.

For those youth who enter the project by age 18, the requirement described in item four, above, will include community service agencies that provide services in the areas of adult mental health, social services, vocational counseling and rehabilitation, higher education, criminal justice, housing, and health. It is also critical that families be involved discussions about every element of service provision to accommodate their needs and backgrounds.

The **geographic service boundary** for the Connections for Kids is Craighead County, (which includes the city of Jonesboro), Arkansas. Based upon ARKids Count CLIKS (County-City-Community Level Information on Kids--CLIKS), there are 19,809 children in Craighead County. Currently, there are 14,285 children between 5 and 18 enrolled in county schools (Jonesboro Sun). A few hundred children are either being home schooled or have left the school system, but there are no official numbers of these children. Current estimates are that, of all school children, 83% are Caucasian, 11% are African American, 3% are Hispanic, and 1% are Asian. There are very few American Indian/Native Alaskan children. From the 1990 - 2000 census, the Hispanic population of the county grew by 350% (IEA Census State Data Center).

Poverty is a problem across the county. For example, although there are school districts with relatively little poverty, others have up to 85% of their student population receiving free or reduced lunch. Craighead County is situated at the edge of the Mississippi River Delta Region,

and is strongly influenced by the cultural characteristics of generational poverty. Many youth in Craighead County do not have access to a primary care physician, a dentist, an optometrist. Youth are hungry and many are living in sub-standard housing. CASSP funds have often been used to simply provide a mattress on the floor on which a child can sleep. Basic needs (food, clothing, shelter) are luxuries for many of these youth, along with involvement in sports, art or music lessons, scouts, etc. The Jonesboro community is strongly influenced by both the relative stability of its economy and the extreme poverty and high unemployment rate of neighboring communities within and outside the county. With the lure of jobs and services, a growing number of individuals continually relocate to the Jonesboro area. The Jonesboro School District has a poverty index of approximately 40% (2000 census data). Based on national prevalence rates of SED, we estimate that Craighead County has approximately 1000 children with SED (14,285 in schools x median prevalence 07% = 999.95 children) that could be reached through the schools, juvenile justice and child welfare settings if there were a systematic approach to identifying them. Co-occurring substance use/abuse is also a problem in our county. Compared with national averages, students from the Jonesboro community have a higher prevalence of drug use than their peers. For example, of 12th-graders in Craighead County, 25% have tried some kind of drug, and 33% are heavy alcohol users (CLIKS–2002 data). Many children in Craighead County do not receive services they are entitled to receive; in 2001, 59% of children eligible for Medicaid did not receive Medicaid services (CLIKS–2002 data). Parents are often unaware of entitlements and services. Access to services is also a problem; many families simply have no dependable transportation. As they seek help they are often referred to many different entities, but to no one who says "Yes, I'LL help you navigate through the process." Connections for Kids will put a system in place that allows for clear identification of those youth most "at risk", support to their families through individualized Care Teams, and wraparound best practices so families can help their children succeed in home, school, and community.

CURRENT CAPACITY

There is tremendous need for mental health services in Craighead County; in the 2002 fiscal year, Mid-South Health Systems served hundreds of children:

- 525 children for diagnosis and evaluation
- 510 children for case management
- 787 children for individualized service planning
- 722 children for outpatient services
- 1066 children for professional consultation/medication review

These children represent a significant percentage of children in the county; however, only a portion of the children with unmet needs. Given the nature of the Delta region, with poverty, lack of resources, etc., it would be expected that the numbers of children served would be much greater, and would include a number of children with SED, illustrating again the need for aggressive outreach to identify these youth earlier and across child-serving settings. The local community mental health center has the core capacity to serve these children - Mid-South Health Systems in Jonesboro serves 7 counties (Clay, Craighead, Greene, Lawrence, Mississippi, Poinsett, and Randolph Counties). Mid-South health systems currently provides the following core mental health services:)1Diagnosis and Evaluation; 2) Care Management; 3) Individualized Service planning; 4) Outpatient services (e.g., individual, group, and family counseling; professional consultation); 5) School-based services; 6) Emergency Services (e.g., crisis intervention, crisis outreach); 7) Respite Care; 8) Therapeutic Foster Care; 9) Transition to Adult Services

Some core services are currently unavailable or in development, such as intensive home-based services for children at risk of removal from the home and those returning from placement. Intensive day treatment services are also needed, but efforts are underway (stimulated by this grant initiative) with schools and other agencies to develop a day treatment program. Mid-South Health System will collaborate with St. Bernards Behavioral Health of Jonesboro (inpatient treatment center) to designate 3-4 beds for youth requiring acute hospitalization. In response to St. Bernards commitment, MSHS will provide a child psychiatrist to provide clinical assistance.

Our county has the potential to integrate multiple services and supports from a variety of agencies. For example, Jonesboro has a faith-based youth facility to serve children in low-income brackets. The local Parks and Recreational Department has initiated soccer and basketball programs (sponsored in part by the Safe Schools/Healthy Students initiative). Therapists and case managers have been added to many schools (also part of the Safe Schools initiative and the 21st Century Grant). We have many critical community supports to offer children and families but they are not coordinated. Connections for Kids would coordinate comprehensive services and community supports for children and their families in the target population, thus enriching this community, and over time, other counties and the state.

Connections for Kids will have profound significance for Craighead County's children with SED and their families, improving access to care, ensuring coordinated care, and best practice services, treatments and supports. The planning and delivery of comprehensive individualized services and supports will be ensured through our partnerships with key child- and family-serving agencies, including schools, child welfare, juvenile justice, and primary care, as well as community agencies and organizations. The SOC will collaborate fully with **other Federal, State, and local programs, and reform initiatives**. These include agencies providing the following entitlements: Title XIX, Title IV-A, Title IV-B and Title IV-E of the Social Security Act, EPSDT program, and IDEA.

The SOC will build upon collaboration realized through our federally funded Safe Schools/Healthy Students (SS/HS) Grant, awarded in 1999. This $9 million dollar initiative was developed by a cross-section of school and community leaders now expanded to eight county school districts, four mental health associations, county and city law enforcement, Arkansas Sate University College of Education and the Department of Psychology and Counseling, Greater Jonesboro Chamber of Commerce, University of Arkansas Area Health Education Center, Jonesboro Parks and Recreation Department, Craighead County Extension Office, United Way, and several other community, civic, youth and faith-based organizations. We have seen ownership and commitment through full sustainability of $1.8 million of the $2.8 million annual budget. The SS/HS Initiative provided mental health services to students and their families at school-based sites and established a behavioral/alternative day school. This was accomplished through partnerships that placed case managers and therapist in school settings to promote better access to mental health services, identification of students with mental health needs, as well as prevention programs. The mental health professionals were the focal point for communication among mental health staff, school administrators, teachers, parents and juvenile justice.

As a part of the SS/HS Initiative, PBIS (Positive Behavior Intervention System) was successfully piloted in the Jonesboro School District, which we will expand to all districts in the county. PBIS (Sack, 1999) is a successful program that goes beyond a school discipline code and involves a system of goals and methods aimed at teaching students appropriate conduct. Robert H. Horner and George Sugia, researchers at the University of Oregon, have worked with teachers and administrators to bring together behavioral theories and methods that other researchers have long advocated. Dozens of schools have adopted PBIS and report impressive results, e.g., declines in office referrals for disciplinary action, overall improvement in the school climate, and a better approach to discipline. Some of the research suggests that it may help keep students out of special education and provide better ways of supporting students with disabilities who are included in regular classes. Horner and Sugai use a pyramid to show three levels of behavior in schools. According to their model, 80 to 90 % of students do not have serious behavior problems, but schools often mistakenly believe that those children are well versed in appropriate behavior. Students who are at risk for problem behavior typically make up 5 percent to 15 % of the school's population. These students may need some individualized services and treatment, but, with some coaching, may respond to school-wide structure and behavioral supports. At the top of the pyramid, roughly 3-5 % are students with complex and serious needs, often accompanied by chronic and intense problem behavior, who need highly individualized care beyond the school-wide model. The researchers say their model helps quickly identify such students and mobilize needed individualized and comprehensive responses. Not surprisingly, the program is highly praised by the U.S. Department of Education's Office of Special Education

and the office of Safe and Drug Free Schools. Both departments have contributed significant funding to disseminate the finding in the schools. Once a school determines that school-wide model will meet its needs and everyone commits to the structure, a data-collection system is developed. Administrators track data on behaviors that interfere with the learning experience, e.g., how many students are referred to the office, for what offenses, and where the violations took place. The Oregon team created an internet-based system to track this data. These Jonesboro Schools would utilize a software tracking system developed through the Safe Schools/Healthy Students initiative specifically designed to track similar data.

Connections for Kids will build upon its current Memoranda of Agreement, working through its Community Collaborative to develop a **memoranda of understanding** (MOU) meeting all the specifications of the cooperative agreement with the emerging local family support organization when it has been fully developed, child-and family- agencies and providers for delivery of services available under Federal entitlements described above, and with other key partners including primary care providers.

SECTION B: IMPEMENTATION PLAN

A. PRIMARY GOALS AND OBJECTIVES

The primary goals and objectives of Connections for Kids are as follows:

1. Develop a comprehensive SOC in Craighead County. *The purpose of this goal is to ensure that a full array of services is provided to children in the target population and their families. Services will be provided within home, school, and community; they will be easily accessible, strengths- and need-based, individualized, comprehensive, and integrated with informal resources and supports.*

Objective #1: ***Create a unified approach among area agencies***, e.g., Juvenile Justice, public schools, Department of Children and Family Services and mental health service providers, to identify children who fall within the target population.

Objective #2: *Develop collaborative infrastructures* to ensure that existing and new resources (e.g., funds, staff and training efforts) promote, support, and sustain mental health services for these children and their families in their homes, schools and community in an integrated, comprehensive system that spans agencies and traditional boundaries.

Objective #3: *Develop structures and procedures* for prevention, early intervention and treatment of SED across the child-serving sector, along with comprehensive delivery strategies where and when children/families need them, e.g., Positive Behavior Interventions and Supports (PBIS) in all Craighead County schools.

Objective #4: *Engage families, informal helpers and community asset gatekeepers* in planning and implementation of the SOC. Mobilize community leaders and helpers as full partners in collaborative infrastructures to inform, guide, and sustain the SOC, and help ensure sources of enduring social supports for children and their families.

Objective #5: Establish comprehensive training, technical assistance and workforce development activities with, full family involvement, that are informed by evaluation findings, emerging child and family needs, and promote the highest quality of culturally competent services, supports and resources for the SOC.

2. Implement wraparound planning and practice models to deliver a broad array of best practice, evidence-based, and outcome-accountable services and supports. *The purpose of this goal is to ensure that quality mental health and related services are responsive to the real time needs of children and their families through individualized Care Teams. Wraparound planning and practices will engage public and private providers and become the new norm for all service delivery.*

Objective #1: *Establish new practice models* within the context of child-serving agencies that ensure adherence to strengths-based wraparound approaches while meeting the core mandates of the agencies. Individualized Care Teams will operate within the Juvenile Justice system, with child welfare partners, and within the school systems.

Objective #2: *Develop new core and related mental health services* in the community to fill existing service gaps and those identified through Care Teams. Best Practice and Evidence-Based Intervention models will be utilized to develop these services, which will be needs driven and delivered within a wraparound approach.
Objective #3: *Mobilize and link informal resources and supports* with formal services through Care Teams. Innovative nontraditional supports will be promoted through systematic family and community engagement to ensure the broadest possible inclusion of informal helpers.
Objective #4: *Establish Care Team outcomes accountability* through wraparound practice models for the mix of formal services and informal supports employed. Ensure fidelity to wraparound planning and practices through cross-system training, intensive technical assistance, and utilization of 'quality control' tools such as the Wraparound Fidelity Index.
3. Incorporate process and outcome evaluation to enhance the effectiveness of the SOC. *The purpose of this goal is to ensure that the quality of care is continually monitored and improved, and that services, supports, programs and systems implemented in the SOC achieve results directly attributable to the SOC. Results will be applied to make mid-course corrections, inform program, policy and training content.*
Objective #1: *Work closely with the National Evaluators* to (a) ensure that the national goals are being accomplished (e.g., contributing to the national effort to promote national policies for SOC), (b) provide and obtain feedback on strengths and weaknesses of the local project, and (c) enhance the program (e.g., improve services, develop policies, and sustain the SOC).
Objective #2: *Measure the effectiveness of the SOC* based upon child and family outcomes, program and system outcomes. Include measures of functional *and* clinical outcomes directly attributable to the SOC. Include measures that address changes in family involvement, resource coordination, service access, service array, use of out of home placements, fiscal policy, cultural inclusion and responsiveness directly attributable to the SOC.
Objective #3: *Use data to improve the SOC.* Establish systematic feedback loops to inform all partners of data results. Establish methods to routinely apply those results to inform practice, service development, training, program and policy development. Ensure that the feedback loop process is sustained.
Objective #4: *Develop key roles for families in the evaluation process.* These will include but are not limited to planning, participating in evaluation activities, formulating feedback loops, analyzing results, improving the process, and presenting findings.
4. Ensure meaningful family involvement in all aspects of the SOC. *The purpose of this goal is to ensure that the perspective and knowledge of family members is valued, and that it enhances the development, implementation and sustainability of the SOC. Family and youth leadership roles will be identified, concretely supported and sustained.*
Objective #1: *Promote the development of a family-run, family-driven support and advocacy organization.* Assist families to build a local chapter of the Federation of Families for Children's Mental Health that is sustained beyond the period of federal support. Develop specific funding, policy, training and leadership support mechanisms to ensure success.
Objective #2: *Engage and actively support families and youth* as full partners in the planning, implementation, and evaluation of the local SOC. Families and youth will be vigorously supported to play leadership roles in collaborative infrastructure, in the development of programs, monitoring, training, and policy for the SOC.
Objective #3: *Establish, support and sustain family-lead practice norms* through implementation of Care Teams which will ensure the active participation of families in decisions about the care of their child, ensure services provided in the SOC are driven by the unique strengths and needs of each child and family, result in meaningful outcomes, and are integrated with enduring social supports.
Objective #4: *Establish, support and sustain new roles for families and youth as leaders* in program and policy arenas at the local and state levels. Leadership roles for family members in Positive Behavioral Interventions and Supports (PBIS) will be developed and sustained.
5. Embrace cultural competence in the design and implementation of the SOC. *The purpose of this goal is to ensure that the SOC respects, honors, effectively mobilizes and*

responds to the racial, ethnic, cultural, and socioeconomic diversity of families and their community. Family, neighborhood, and community cultural resources, needs and assets will inform and drive the development of a culturally competent SOC, engaging informal supports and building sustained community commitment.

Objective #1: *Individuals representative of the cultural diversity of the target population will be enlisted as full partners* in all levels of the SOC, including governance, evaluation, training, program design, implementation, and delivery of services.

Objective #2: *Systematically assess the range of cultural diversity, assets and needs* of the target population and the County to ensure a culturally competent SOC

Objective #3: *Establish culturally competent policies, procedures and practices in the SOC* by fully incorporating knowledge, attitudes, and practices of diverse populations in the design, implementation, and monitoring of practice, programs and systems. This will include attention to recruitment of culturally diverse providers and programs.

Objective #4: *Develop and sustain cultural competence training capacity* within the SOC to inculcate culturally responsive in practices, program development and systems reform.

B. INFRASTRUCTURE DEVELOPMENT

The infrastructure for the SOC will be phased in throughout the period of federal funding. SOC infrastructure will build upon the foundation laid by the CASSP governing body in Craighead County and the Safe Schools/Healthy Students initiative. The Community Collaborative (governance body for the SOC), working closely with the Administrative Team through strategic planning and subcommittee structures described in the Administrative Team section, will develop policies and procedures necessary to ensure the development of infrastructure described below. Key administrative procedures to be developed include:

1. DEVELOPMENT OF THE INFRASTRUCTURE

a. Systems Integration: Connections for Kids will organize and coordinate resources available through Federal, State and local human service systems through the development of a Community Collaborative. The Collaborative will systematically expand and strengthen the foundation of existing collaborations, by including representatives from families and youth in the target population, family advocates, community stakeholders and child-serving agencies as described in #2 below. The Collaborative is the local governance structure that designs, manages, monitors, sustains and is accountable for the SOC. The lead agencies for SOC (Mid-South Health Systems and Jonesboro Public Schools) are responsible for convening, staffing and supporting the work of the Collaborative, where youth, families, and community stakeholders are full partners. The Collaborative is the locus for creation of a single SOC that will be financially sustained through collaborative and integrated funding streams. The Collaborative is responsible for coordinating and monitoring fund investment and integration. It will drive the consolidation of existing fragmented, categorical service funding streams, the investment of State, local, and grant funds to ensure SOC accountability, growth and sustainability. The Collaborative will utilize strategic planning as a key method to organize, benchmark and monitor systems integration. Through this process, it will: 1) organize and consolidate existing categorical service funding streams and optimize alternate and new service funding streams; 2) oversee and promote SOC services by supporting and monitoring the status of Care Teams; 3) resolve barriers encountered by the Care Teams; ensure that child serving staff from related agencies are full participants; 4) ensure expansion of existing services required to meet the needs of the target population in their homes, schools and community; 5) formulate policies and procedures necessary for a healthy, sustained, and replicable SOC; 6) ensure that families and youth are full partners in all aspects of the SOC; and 6) ensure cultural competence of all aspects of the SOC. A key element in systems integration for this SOC_is the development of Positive Behavior Intervention Systems (PBIS) throughout the public school systems, as described in Section A.

The State of Arkansas is fully committed to the successful development, statewide replication and sustainability of the SOC. The State mental health authority will ensure that a representative from the Arkansas Division of Behavioral Health serves on the Collaborative who

will be empowered to take a lead role at the state and local level to 1) develop statewide policy and fiscal initiatives to replicate the SOC model across Arkansas, and 2) include implementation of the local SOC in statewide policy and fiscal initiatives to increase the likelihood of sustainability. Ann Wells, Assistant Director Children Services, for the Division of Behavioral Health will ensure timely and relevant development of replication of the SOC during and after the 6 years of Federal funding. Connections for Kids, through it's Collaborative, will work closely with the state mental health authority to ensure that the statewide replication plan will in no way compromise the intent of the cooperative agreement program to develop systems and services of community-based SOC in specific jurisdictions. At the State level, Division of Behavioral Health will actively support and promote these sustainability and replication requirements. The implementation of the local SOC will be included in the goals of the State's Community Mental Health Services Block Grant Plan and in the goals of the State Mental Health Plan for children with SED, submitted under public Law 102-321.

b. Interagency Collaboration: The Collaborative will be the hub for systems integration and interagency collaboration. In order for individualized Care Teams to successfully implement comprehensive Care Plans, decision-makers from all community agencies and organizations that serve and support families must work together as a team, formalizing arrangements to promote shared decision-making and accountability. While Mid-South Health Systems has the capacity and authority to provide mental health services in the community, and all Craighead County schools will implement PBIS as part of Connections for Kids, it is essential that services and resources from *all* child-serving sectors be integrated and made readily accessible to the target population. The Collaborative will ensure that the broadest range of services and resources possible is made available, and will include representatives of all child-serving agencies delivering services in the areas of mental health, education, child welfare, child protection, juvenile courts and corrections, primary health care, and specialty services such as substance abuse treatment and prevention, vocational counseling and rehabilitation. It will also include family representatives of children in care, youth, family advocates (e.g., Arkansas Federation of Families), Arkansas University faculty, nonprofit organizations, and citizen representatives, including members of local business. The Collaborative serves as a unifying structure that organizes services/resources, and empowers local decision-makers and stakeholders to "drive", manage, and monitor systems reform efforts on behalf of the SOC.

This replicable template for collaborative service delivery and policy development will promote and sustain necessary changes to mobilize resources, monitor and support wraparound approaches, and ensure that children and their families receive the support of a unified and durable community effort. An initial Memoranda of Agreement is now in place (see Appendix 1), and will serve as the basis for the Memoranda of Understanding (MOU), to be further refined during in Year 1, to specify the role that each agency plans in the SOC, including each agency's financial or in-kind contribution, official representation in the Collaborative (governance structure), participation in strategic planning, compliance with the National Evaluation, and participation in service delivery tasks. In addition to the formal arrangements described in the refined MOU, formal arrangements will also be stated clearly in policy manuals, Collaborative minutes and other documents shared among the agencies and through the Collaborative. Derek Spiegel, Ed.S., CRC LPC, Technical Assistance Coordinator, will be designated to implement the arrangements described above.

c. Services Integration: Connections for Kids will ensure that children and families in the target population have a unified, efficient and supportive service experience. A holistic approach to early identification and comprehensive service/resource integration is essential to meet the needs of the target population. Services will be planned, delivered and monitored through individualized Care Teams. Care Teams are established, coordinated and monitored by a Care Manager, a person designated to guide a child and family and those who are helping them through the process of developing and implementing an individualized and unified Care Plan. The Care Teams are the 'heart' of the SOC, to ensure successful service integration at the practice level. The Care Team is built around the family so that each family's particular culture, priorities, concerns, and needs may be met. Team members work together with the family to

write an individualized Care Plan based upon the family's functional strengths, and addressing their needs through measurable and meaningful outcomes. The Care Team is unique for each family, comprised of those persons who are important in their everyday lives, including such members as representatives of the family, family advocates, neighbors, extended family members, health care professionals, and representatives of relevant agencies, as well as others who have been requested to participate by the family and the child (unless clinically inappropriate). We will establish Care Teams as the new norm for best practice wraparound service delivery – *one family/one team/one plan* – eliminating service duplication, conflicting mandates and multiple case managers. Care Team services will be initiated, including comprehensive strengths-based assessments, upon identification of each child/family eligible for the SOC. Service objectives from all participating agencies including Federal entitlements and legal requirements for participating agencies (Juvenile Justice, Public Schools, IDEA, etc.) will be integrated in the plan as well as "informal" community/ neighborhood resources, according to the family's needs, strengths, and unique circumstances. The Care Plan will be the transitional planning document to support youngsters as they move across developmental and environmental changes, and older youth that move from child to adult services. Transition issues will also be addressed in the interagency MOU. In the public schools, Care Teams will be fully integrated as within the PBIS model. Individual Education Plan processes will be fully integrated within the Care Team process. In the Juvenile Justice system, Care Teams will become part of an integrated screening, assessment and response protocol. Care Teams will also be initiated for children in the target population who are involved in the child welfare system, and for those in an out of home placement as a key mechanism to fully transition these youth back to their family, school, and community connections.

In Connections for Kids, services will not only be integrated at the community level, but also within the school systems, based on the Positive Behaviors Interventions and Supports (PBIS) system. As described in Section A, PBIS is a school-wide system of structurally supported positive discipline. For children with the most complex, challenging needs (an estimated 3-5%) mental health screenings and assessments will be initiated, including criteria for the target population. For those children who meet the eligibility threshold, a Care Manager is immediately assigned to work with the child and family, initiates the strengths-based wraparound process that will establish the Care Team and subsequent individualized Care Plan in partnership with the child and family and school staff, comprehensively addressing mental health, academic and other needs, as described above. Two of Jonesboro's schools are in the initial stages of PBIS. West Elementary School is starting its second year; the Sixth Grade Academic Center is starting its first year. While many districts implementing PBIS begin seeing improvements during the first year, they indicate that it takes up to four year to fully develop and implement a complete system. Intensive multi- level training and coaching help ensure fidelity to the PBIS model and successful implementation. Connections for Kids will include 8-10 sites per year to the PBIS system; elementary schools during Years 1 & 2, and secondary schools by Year 3. At the end of Year 4 all schools in the county would be implementing PBIS as a key component of the SOC.

d. Wraparound process: Connections for Kids will operationalize the five key elements necessary to implement wraparound: 1) the Community Collaborative; 2) interagency agreement (the MOU); 3) Care Managers; 4) Care Teams; and 5) an individualized/unified Care Plan. The Project's Care Teams will utilize wraparound processes. Thus, Care Teams will be holistic and outcomes-driven, build upon functional strengths, and comprehensively address needs within a family and community context, regardless of whether the services offered "fit" into a specific program, financial, or categorical box. This will include services that may exist within the SOC, those that are modified to better respond to real life needs, new services and a broad range of creative, non-traditional informal resources. Many such resources will be available without cost or at minimal cost (e.g. neighbor helping with transportation, civic club support for karate class, peer-to-peer tutoring, counseling or recreation programs offered by communities of faith, etc.). Using volunteer resources, relationships will not be limited by program structures or payment for services delivered, but will build family, neighborhood and community partnerships. These partnerships will help decrease dependency upon formal agency services and remain a strong and

enduring source of family support. Care Teams and Care Plans will be driven by strengths-based assessments and Life Domain planning to help articulate needs and outcomes that are meaningful to families and to assist the professional community to move away from narrowly defined 'service' solutions. Life Domains will include areas such as social, safety, health, emotional, family attachment, living situation, transportation, etc. Consistent with nationally recognized wraparound processes, each Care Team will have a proactive and reactive crisis plan, established upon entry into the SOC and kept current. Funds and resources from all child-serving agencies will be braided (maintaining their source identity, but combined with other such funds to promote comprehensive service responses) in Care Teams. And, **Flexible Funds** will also be available for each Care Team to supplement informal/volunteer resources and to improve the family and community's ability to meet non-reimbursable and nontraditional service and support needs. The Care Team will identify service and flex fund needs under the guidance of the Community Advisory Board. Training and ongoing technical assistance in the wraparound process will be provided for all Connections for Kids participants.

e. Care Review: A Care Review Team will be a component of the Community Collaborative, and will be comprised of interagency representatives and family advocates, to examine how well services are being delivered to individual children and their families. The purpose of the Care Review Team is to share responsibility and accountability to actively promote the delivery of best practice. The Team will: 1) provide support and 'solution finding' to Care Teams that are struggling to plan or implement comprehensive Care Plans; 2) select a set of Care Plans that exemplify the variety of needs found among the target population, along with most frequently encountered service delivery barriers and difficulties; 3) examine other Care Plans and related records, arrange for interviews with the child, key family members, care managers, and other caregivers involved in service delivery, and 4) develop recommendations for improvement of the adequacy, appropriateness, and quality of the services/supports. Special attention will be given to how well each child-serving agency and supports are contributing to meet the individual needs of children and their families in achieving meaningful outcomes. The Care Review Team will hold a standing place on the Collaborative's agenda to report their findings and recommendations.

f. Access: Connections for Kids will ensure access as follows: 1) An efficient 'no wrong door' portals of entry system - Referrals to the SOC can come from any source, into clearly defined portals of entry, including all public schools, Juvenile Justice, Mid-South Behavioral Systems, and the local Dept. of Child and Family Services (child welfare); 2) A family-friendly universal eligibility screening and enrollment process - In each setting, trained staff will conduct a screening and eligibility assessment process. Eligibility Criteria is described in Section A, Target Population. Families seeking access will be fully involved as partners in the completion of these processes, i.e., eligibility will not be an isolated/behind closed doors decision. Eligibility will be provided without regard to race, religion, national origin, sex, physical disability, sexual orientation or other characteristics. Screening and enrollment procedures will be developed with families in the target population during Year 1 to ensure that they are clear, culturally competent, comprehensible and 'family-friendly'. 3) Rapid response - When the child reaches eligibility thresholds, a Care Manager is immediately assigned to work with the child and family, initiates the strengths-based wraparound process that will establish the Care Team and subsequent individualized Care Plan. When children do not meet eligibility thresholds, the family will be actively assisted to access other services/supports. 4) Public awareness: The Collaborative will systematically inform families, youth, agency staff and the broader community regarding access to the SOC through public awareness, education, and promotion of Connections for Kids. Services will originate in the public schools via comprehensive PBIS approaches, in family homes, foster homes (DCFS or self referred), and in the juvenile justice court settings. Services will be easily accessible for children and their families. In cases where children require an out of home placement, a transitional plan will ensure that services are fully integrated in the Care Plan, used only used only so long as necessary to meet measurable functional outcomes, are intensively managed and in place *prior* to the out of home placement. The Care Manager will ensure ready access and communication between the child and his/her family, including transportation if necessary.

g. Financing Approach: Connections for Kids will implement a single SOC that will be financially sustained through collaborative and integrated funding. It will pilot new financial models for the delivery of services that are effective, comprehensive, community based and family-centered, as a template for statewide replication. Changes in Arkansas' Community Mental Health Services Block Grant Plan and the Mental Health Plan for Children and Adolescents with Serious Emotional Disturbances will promote, unify and sustain child-serving efforts in the State in accordance with the principles of SOC. A comprehensive strategic plan will be developed to promote and sustain a fully integrated SOC, including the maximization of revenues and the promotion of integrated funding investment. The financial plan will encourage shifts in organizational relationships among State and local human service agencies. Maintaining and enhancing the SOC will be a primary goal of the partnership between the State, Mid-South Behavioral Systems, the local school system, stakeholder agencies, and community organizations. Through the activities of the proposed project, it is expected that strong evidence of the effectiveness and value of SOC will provide the incentive to remove funding restrictions and barriers to the integration of funding and services. At the local level, the Community Collaborative will identify possible funding streams, identify best uses for those funds, look for alternative community based funding opportunities, and communicate this information to the State level. Mid-South Behavioral Systems is the fiscal agent for the grant, and as a designated RSPMI provider, is compliant with the State Medicaid Plan, and thereby qualified to receive Medicaid payments, Child Health Insurance Program, and private insurance payments. All participating agencies are committed to providing **Nonfederal Match Dollars** to ensure the success of the Collaboration. The Community Collaborative is responsible and has the authority for coordinating and monitoring Project fund investment and braiding of existing cross-agency funds. This group will drive the consolidation of existing fragmented, categorical service funding streams, the investment of State, local, and Project funds into the Collaborative. Flexible funding sources will be identified and developed to meet the individual needs of families, including direct and in-kind contributions from local churches, businesses, service clubs and non-profits. Community foundation funds will also be pursued as a resource. The MOA that will be fully developed in Year 1, will include 1) specific funding and match requirements for services from State and community child-serving agencies; 2) specific criteria regarding access to existing categorical service funds from the public and private sources for which the target population are eligible; and 3) specifically name and define private funds that will be made available to support SOC activities and structures other than services, e.g., training, research, equipment, etc. 4) direct reference to specific protocols developed through the Collaborative that ensure fiscal accountability to each funding source; and 5) specific expectations and requirements regarding the financial support and sustainability of the local family organization (FFCMH chapter) during and beyond the period of federal funding. The Collaborative will require maintenance of effort provisions in the MOUs and resulting contracts developed in Year 1. The Collaborative will also monitor the growth of new dollars and their investment into the new or expanding local SOC. A major strength of our collaborative efforts to date is our successful track record. We have sustained a multi-million dollar mental health component of our Safe Schools/Healthy Students initiative by streamlining and forming cooperative arrangements across multiple agencies. Additionally, Mid-South Health systems already has procedures in place to expand the proposed SOC into the entire seven county service area We recognize sustainability as a vital part of any new initiative and will dedicate our energy and resources to 'institutionalize' the SOC. A key component of sustainability (and replication) will include the goal of improving the statewide Medicaid program and reimbursement system. With a history of commitment to children and families established through the AR Kids program (an expanded health program for low income children in the state), this is a very feasible goal.

h. Workforce Development: Connections for Kids will ensure best practices and maximum effectiveness of services that are professional, competent and consistent with SOC values and principles through comprehensive training and technical assistance. A goal is to increase the knowledge and skills of the workers who manage the SOC and delivery services to children and families. Cross-agency training will cover the spectrum of skills, knowledge and competencies

necessary to implement high quality, comprehensive, inclusive, culturally sensitive, and family-centered practice for children, families and communities. In-service training will include initial orientations for all Project participants, topic-specific seminars, skill-based workshops, community/University SOC institutes, train the trainer opportunities, and continuing education units. However, training alone is not sufficient to transform the practice landscape that Connections for Kids envisions. Intensive technical assistance opportunities will be developed so that participants can practice and hone the value-based skills necessary to actualize the SOC. These technical assistance activities will include Peer-to-Peer Care Team practice groups and mentoring of new Care Teams. Specialized training and technical assistance will also occur for the Positive Behavior Interventions and Support (PBIS) initiative that is core to the comprehensive SOC for Connections for Kids. An intensive PBIS training curricula will target PBIS coordinators, coaches, and the universal, targeted and intensive school-based teams, consistent with emerging nationally accepted practices. An active Workforce Development subcommittee will be developed via the Community Collaborative to ensure family, cross-agency and community inclusion in the development and implementation of these workforce strategies. Activities in Year 1 will include a training needs assessment at the state and local level. The Arkansas Federation of Families for Children's Mental Health will take the lead in assessing family training needs, mapping out strategies of culturally diverse inclusion, ensure stipends, child care and other sources of needed family support are integrated into the workforce training and technical assistance plan. From these assessments, a comprehensive workforce-training plan will be developed. During Year 1, we will develop a partnership with Arkansas.State University. Models for Public Academic Partnerships will be explored, including the PEN-PAL approach in North Carolina. We will develop and refine our planning in Year 1. The focus of this work will be on developing collaboration skills, encouraging increased cross-disciplinary field placements, modifying courses to integrate SOC principles/practices into the academic programs. Goals will include: 1) training and support for Collaborative members interested in providing assistance in curriculum development, review, and/or delivery; 2) Collaborative representatives to develop and review curriculum; 3) Collaborative representatives to work with faculty and agency providers in the classroom; 4) Field-placement opportunity for students; and, 5) Special roles for families in curricula development and instruction.

i. Support from Community Leaders: Connections for Kids will leverage the grant as a catalyst to promote a shared vision and civic commitment among our community's citizens, businesses, agencies and organizations for comprehensive and sustained system improvement for our children and their families. Building upon the commitment of the City of Jonesboro, as applicant for this proposal, we will work hand in hand with the Mayor to systematically seek out key community decision-makers and opinion-leaders (reaching out to include those from racial and ethnic minority populations) in business, the faith community, in higher education through Arkansas State University and our community college, along with our judges, agencies, and county government officials. During Year 1, we will work with these leaders to 1) promote their understanding of SOC and its relevance to business, higher education, and civic agenda; 2) identify and prioritize mutual interests; 3) identify ongoing opportunities and forums that will have greatest impact in creating and mobilizing community support and ownership for SOC throughout and beyond the period of federal funding; and, 4) create ongoing communication strategies to link emerging financial needs of the SOC with financial resources in the business, faith and city/county government arenas. Through the visible involvement of our community leaders (as guest speakers, as architects of public statements endorsing the SOC, and as key representatives on our Community Collaborative) we intend to clearly demonstrate the value of SOC as a key strategy to help strengthen our community, leverage diverse and sustained financial support, and ensure that SOC becomes woven into the 'fabric' of the community.

2. DEVELOPING A SYSTEM OF CARE

Connections for Kids will develop and sustain a strong, interactive and responsive administrative structure to ensure the success of the SOC, including:

a. Clinical Network: As noted in Section A, Craighead County has a set of services currently available, including Diagnosis and Evaluation, Care Management, Individualized Service planning, Outpatient services (e.g., individual, group, and family counseling; professional consultation), School-based services, Emergency Services (e.g., crisis intervention, crisis outreach), Respite Care, Therapeutic Foster Care, and Transition to Adult Services, but there are substantial gaps in the array of services, treatments, and supports needed to serve children and SED and their families. There are also significant limitations in capacity and access to existing services. Connections for Kids will enhance and develop its clinical network to the highest possible level of quality, ensuring ready access, and sufficient capacity to serve as a model of system reform in Arkansas. We will address the development of our clinical network as follows:
(1) Establish new practice models, new core and related mental health services in community settings. Individualized service planning, implementation and monitoring will occur through Care Teams for each child and family in the target population. However, the array of services, and access to those services will be designed to maximize a 'goodness of fit' among children/families and the child-serving sector, including: (a) The school environment: As described previously, a key aspect of innovation in the Project is the integration of a comprehensive SOC with implementation of evidence-based Positive Behavioral Interventions and Supports (PBIS) in all local school districts. The SOC will include 8-10 sites per year to the PBIS system; elementary schools during Years 1 & 2, and secondary schools by Year 3. At the end of Year 4 all schools in the county would be implementing PBIS as a key component of the SOC. Family representatives will be key partners in PBIS operations through newly State-mandated Parent Resource Centers, further integrating PBIS with SOC implementation; (b) Adjunct to the court setting: Rapid assessment for mental health needs, access, and comprehensive service responses will be established through co-location of Project staff in the court setting to initiate Care Teams and divert children in the target population from over utilized out of home placements. Specialized treatments, such as Multisystemic Therapy, known to have positive impact for court-involved youths, reducing rates of antisocial behavior, out-of- home placements, and empowering their families to resolve future difficulties, will be part of the new service array; (c) In the child welfare arena: During Year 1, we will establish comprehensive screening processes to help identify and respond to the mental health needs of the target population served in the child welfare system. Also during Year 1, the Project will actively partner with our local Department of Child and Family Services to determine how the SOC can help address Adoption and Safe Families Act (ASFA) requirements. During this planning year, we will jointly explore how evidence-based services such as Treatment Foster Care can be added to the service array, and develop plans to integrate vital Family Support activities through the work of Arkansas' Federation of Families organizations. (d) Children in out of home placements: Intensive outreach to children in out of home placements will be initiated by Year 2, and result in formulation, through Care Teams, of active transition plans to bring these children back to their homes, schools and community. Respite, independent living, and transitional services will be added to the service array to help ensure successful and enduring reintegration of these children. Service and support needs identified through individual transition plans will help inform the Community Collaborative of additional resources required to reduce the risk of out of home placements for these and other children in the target population, along with the needs of their families. (e) Through the primary care provider system: Through collaboration with the primary care provider system, including family physicians, pediatricians, and public health nurses, systematic referral procedures into the SOC will be implemented, along with procedures for including primary care providers in individualized Care Teams utilizing wraparound processes.
(2) Connections for Kids will actively seek training and technical assistance opportunities offered by the Comprehensive community MH Services Program for Children and their Families to strengthen the quality of the clinical network. The Technical Assistance Coordinator, working closely with the Community Collaborative, will ensure that information gleaned from these opportunities are widely disseminated and strategically applied to improve the clinical network.
(3) Findings from the National Evaluation will be systematically utilized to further identify gaps, make adjustments in the clinical network and how it functions. The application of these findings

to clinical network improvements will be ensured by the Project's local evaluation staff and plan, measuring data regarding the effectiveness of the SOC based upon child and family outcomes, program and system outcomes, establishing systematic feedback loops with the Community Collaborative to inform all partners of data results, and establishing methods to routinely apply those results to inform practice, service development, training, program and policy development. (4) Federal or professional practice standards and guidelines for the delivery of children's mental health services will guide the development and implementation of services in our clinical network, such as intensive care management through Care Teams, therapeutic foster care, and home-based crisis intervention. Connections for Kids intends to implement evidence-based interventions such as Cognitive Behavioral Therapy (CBT), Multisystemic Therapy, Treatment Foster Care, and Positive Behavioral Interventions and Supports.

b. Governance body: Connections for Kids will establish a Community Collaborative as the local governance structure that will have the authority to make policy decisions for the SOC; it designs, manages, monitors, sustains and is accountable for the SOC. The lead agencies for the SOC (Mid-South Health Systems and Jonesboro Public Schools) are responsible for convening, actively staffing and supporting the work of the Collaborative, where youth, families, and community stakeholders are full partners. The Collaborative would be expected to meet on a monthly basis, to ensure relationship-building and sufficient dedicated effort to accomplish agenda. The collaborative will include a representative from the Jonesboro Mayor's office, representatives of all child-serving agencies delivering services in the areas of mental health, education, child welfare, child protection, juvenile courts and corrections, primary health care, and specialty services such as substance abuse treatment and prevention, vocational counseling and rehabilitation. It will also include family representatives of children in care, youth, family advocates (e.g., Arkansas Federation of Families), Arkansas University faculty, nonprofit organizations, representatives of the faith community, and citizen representatives, including members of local business. A representative from the Arkansas Division of Behavioral Health will serve on the Collaborative who will be empowered to take a lead role at the state and local level to 1) develop statewide policy and fiscal initiatives to replicate the SOC model across Arkansas, and 2) include implementation of the local SOC in statewide policy and fiscal initiatives to increase the likelihood of sustainability. The Collaborative will also reach out to enlist representatives of racial and ethnic minorities as full membership partners. The Collaborative will develop and uphold a Memoranda of Understanding and other formal agreements that: require shared responsibility and accountability between the child serving agencies (including those from the State and other political subdivisions of the State), ensure that cooperative agreement funds are expended appropriately within the community, holds the SOC accountable for meeting high standards of care, including standards for cultural competence, family involvement, and standards of practice that have been shown to be effective through research and evaluation studies. The Collaborative will establish mechanisms (such as bylaws, strategic plans, subcommittees and communication protocols), to ensure that representatives are aware of relevant reform efforts in Arkansas and incorporate these into the SOC as required/appropriate, to monitor the clinical and functional outcomes of children to ensure that services are making a positive contribution to the well-being of the children and their families, e.g., as through the Care Review process. The Administrative Team, described below, will actively support, adequately staff and be ultimately responsible for the success of the Collaborative. The Administrative Team will ensure that a Chair and Co-Chair are elected, one of who will be a family member.

c. Administrative Team: Connections for Kids will establish an Administrative Team, comprised of the principal investigator, project director, clinical director, key evaluator, family coordinator, youth coordinator, technical assistance coordinator, and communications manager, who will be supervised by the Community Collaborative. This Team will have the ultimate responsibility to manage, implement and develop the SOC, working through, actively supporting, and adequately staffing the Community Collaborative to accomplish key tasks. A fundamental first step will be the development of an overarching strategic plan. The resulting plan will be a 'living document' to guide the Collaborative, operationalize implementation, and

monitor progress through clearly defined SOC benchmarks. It will under-grid the Collaborative agenda, be updated as needed for mid-course corrections, but at least annually, and will clearly define mutual responsibilities and accountabilities for all Collaborative partners through by-laws, MOA, policy and procedural documents, subcommittees, and related structures. Standing teams or subcommittees will be developed to ensure inclusion, dedicated focus, and creative yet accountable progress. Each team/subcommittee will have a designated leader; those leaders will work together with the Administrative Team as an Executive Committee to ensure unification of effort, accountability to the grant, develop and monitor the collaborative infrastructure necessary at the local and State levels to ensure full Project support, replication and sustainability. Key consultants will provide guidance on an as need basis. The Administrative Team will actively support, adequately staff and be ultimately responsible for this work, assisting the Collaborative to establish subcommittees, teams or workgroups that cross-inform each other, are highly inter-related and interactive, while dedicated to key tasks:

1) Services and Resources – ensure service coordination among child-serving agencies, with the primary care system,+ analysis of service gaps, new service needs; linkage of mental health services with nonmental health services; analysis of informal supports, including alternative healing practices representative of racial or ethnic minority groups in the community; linking formal services with informal supports; ensure services are of the highest possible level of quality, outcomes-accountable, provided within best practice wraparound Care Teams, adhere to Federal and national practice standards, include evidence-based components, and provide a 'goodness' of fit for the strengths, needs, and cultural preferences of the target populations.

2) Finance – identify all relevant local state, and federal funding streams; analysis/plan for integrating funding streams as appropriate; interactive development and monitoring of the budget established by the Administrative Team for expenditures of service funds for required services; development and monitoring of contract award processes for service delivery, training, technical assistance, evaluation, and social marketing; development and monitoring of Flexible Funds processes, nonfederal match commitments and sustainability plan.

3) Leadership, Training/Technical Assistance & Workforce Development – establish leadership development and support plan/protocol; process to assess ongoing training and technical assistance needs for all partners, processes for subcommittees/teams to inform ongoing training/TA plan, a feedback loop to ensure that training/TA is meeting needs and impacting practice, programs and policies; develop plan/protocol for ongoing linkage with CMHS training and TA processes; for initial and ongoing training and TA that adheres to adult learning best practices, infusion of SOC principles/practices into existing leadership training, child-agency training, and core curricula of human services coursework through the Arkansas State University partnership; develop plan/protocol to ensure cultural competence and full and active youth and family involvement in all aspects of planning, curricula development, delivery, monitoring.

4) Evaluation & Quality Improvement – ensure that findings from the National Evaluation and local evaluation shapes future program direction, decisions about practices and policies that work, the development of a managed care approach that eliminates current fragmentation and integrates public and private provider resources; ensure that measures of SOC effectiveness are based upon child and family outcomes, program and system outcomes; ensure cultural competence, that youth and families are full and active partners in all evaluation activities, and that the evaluation goals and objectives described in this application are achieved; utilize fidelity measures such as the Wraparound Fidelity Index; monitor the extent and quality of implementation of individualized service plans, the extent to which living and service placement for children are in the least restrictive, most normative, safest, and most clinically appropriate environments, and the degree to which care management and other services enhance the strengths, resilience, protective factors, and well-being of the child and the child's family.

5) Care Review – establish plan/protocol to ensure that all activities described in Section B, 1-e (Care Review) are accomplished, active feedback loops to inform the Collaborative and its teams/subcommittees regarding the 'real time/real life' strengths and needs of the target population as the heart and ultimate test of SOC success;.

6) Public Awareness/Social Marketing – develop a social marketing plan that is culturally and linguistically competent that ensures implementation the Social Marketing requirements described below. Work closely with and actively support the role of families and the Federation of Families in all planning and activities. Seek out and actively include representatives of racial and ethnic minorities in the community to help ensure a culturally competent process and to engage these populations in the SOC effort

7) Youth and Family Involvement & Cultural Competency –ensure full Youth and Family involvement/partnership in all SOC activities in concert with AFFCMH; plan sustainability of the family organizations; for increasing youth and family participation of racial and ethnic minorities in the SOC; ensure that disparities in access to care, quality of mental health services, availability of effective clinical interventions, satisfaction with services, and other SOC outcomes for children and their families from racial or ethnic minority groups are addressed, and implementation of Family, Youth and Cultural Competence activities described in Section E.

d. Training Capacity: There are limited resources at present to address the training needs of the SOC. Training activities are primarily those within each agency, and rarely cross those boundaries. Training and technical assistance will be utilized to assist with planning, development and operations of the SOC. We will ensure that training curricula and delivery is culturally competent, fully inclusive of families in its development and delivery. Resources will be budgeted to hire trainers and consultants with specific expertise relevant to the needs of the SOC. Through its Community Collaborative structure, a comprehensive training and TA plan will be developed, including mechanisms for continuous assessment of TA needs, ongoing planning, and implementation of training and TA activities. The Collaborative's Training/TA and Workforce subcommittee will assume this function, assisting with identification of resources to address the training and TA needs of each stakeholder group associated with the SOC. All training activities will be organized and implemented to address the developmental needs of the SOC. Topics will include: system leadership, fiscal management, personnel management, implementation of clinical interventions and the wraparound process, quality improvement and evaluation. Connections for Kids will model its training delivery system consistent with best practice examples described in the *Systems of Care: Promising Practices in Children's Mental Health, 1998 Series, Volume V* monograph, Training strategies for serving children with serious emotional disturbance and their families in a system of care.

e. Social Marketing: The SOC will develop a social marketing plan that is culturally and linguistically competent and includes: 1) informing the public about the SOC and its services, 2) educating the public about the needs of children with SED and their families, and 3) recommending good mental health practices/best practices for meeting those needs. We will actively foster public engagement to build public support and the 'will' to address challenges and create solutions on behalf of the SOC. A half-time equivalent position will be designated as the social marketing-communications manager. Further, the SOC will provide support to the AFFCMH and the emerging local chapter to implement outreach strategies with families of children with SED, including but not limited to those who are from racial and ethnic minority groups in our community. Working through our Collaborative, we will implement a social marketing strategy that determines the informational needs of target audiences, develop different messages for different groups, materials, and activities that are in compliance with Title VI of the Civil Rights Act, national Standards on Culturally and Linguistically Appropriate Services in Health Care, and the standards identified in SAMHSA's Cultural Competence Standards in managed Mental Health Care Services.

f. Performance Standards: As described above (Administrative Team), the Community Collaborative will develop a comprehensive strategic plan, including operational benchmarks that mirror the goals, objectives and strategies of this proposal. The Executive Team of the Collaborative, working closely with the Administrative Team, will ensure that the SOC benchmarks measure the degree to which the SOC has met quality and effectiveness goals, including but not limited to: access, capacity, clinical outcomes, service provision, infrastructure development, training/technical assistance and workforce development. Evaluation procedures will be established to determine effectiveness in each of the following areas: access (to be

established), capacity (e.g., number served), clinical outcomes (e.g., CAFAS), service provision (e.g., survey of client satisfaction,), infrastructure development (to be established), workforce training (e.g., participant numbers). The local evaluation will provide information on the success of the PBIS model (number of discipline referrals), changes in school suspension, changes in the number of incarcerated youth, and the numbers of out of home placements, among other data.

g. Management Information Systems: The Safe Schools grant provided a computerized system for Jonesboro school district to monitor behavioral concerns, student attendance, etc. This system (Redpoint) will be expanded to all districts in the county. Additionally, the Safe Schools grant provided funding to computerize the county juvenile office. A computerized monitoring system operational within the mental health system, which is fully HIPPA compliant, will provide a means of tracking comprehensive and integrated services within the mental health system. This system will integrate general information, clinical diagnosis and treatment, and progress in meeting child/family outcomes. During Year 1, evaluation staff partners from Arizona State, along with specialized consultants will assist us: 1) in linking these systems, in data storage, management, analysis and reporting; 2) to enhance our MIS to record the type, amount, and cost of services delivered to each child in the SOC, including those reimbursed by Medicaid, covered by cooperative agreement funds, and any other State or private funding streams; 3) ensure a close correspondence between the services delivered as part of the Individualized Care Plan and the services recorded in the MIS. During Year 1, we will also build upon the 3 MIS (in mental health, schools and juvenile justice) to integrate information across the collaborating child-serving agencies, and use this as a tool for service delivery coordination. Our resulting MIS will also have the capacity to integrate child and family outcome data from the National Evaluation. All MIS procedures will be compliant with HIPAA specifications. Each agency has current procedures to ensure that records are kept secure and confidential, which will be expanded to include other child-serving partners in the SOC MIS.

h. Office in the Community: Connections for Kids will establish Mid-South Health Systems Administrative offices as the facility located within the geographic bounds of the SOC, Craighead County. This Office will manage and coordinate service delivery as described throughout this application.

C. SERVICE PROVISION

1. Required Mental Health Services: Mid-South Health Systems will provide a full array of mental health services and supports including but not limited to the following: Diagnosis and Evaluation, Care Management, Individualized Service planning, Outpatient services (e.g., individual, group, and family counseling; professional consultation), Emergency Services available 24 hours a day, 7 days a week (including, crisis intervention, crisis outreach), Respite Care, Therapeutic Foster Care, and Transition to Adult Services. One of the strengths of Connections for Kids is that we will offer comprehensive school-based services through Positive Behavioral Interventions and Supports. We will integrate other evidence-based interventions such as Cognitive Behavioral Therapy, Multisystemic Therapy, and Treatment Foster Care into the service array. Community-based intensive home-based services, intensive day treatment, independent living and therapeutic group-home services (under 10 beds) are gaps in services/capacity that will be developed during the grant period, and in operation by Year 2. These services will be integrated, when appropriate, with establish alternative healing practices of racial or ethic minority groups represented in the community, especially when there are indications that this integration will reduce racial or ethnic disparities in mental health care. .In all cases, services will reflect SOC values and principles, be individualized to ensure cultural sensitivity and clinically appropriate care. All services will be planned, delivered and monitored through comprehensive, individualized Care Teams and integrated Care Plans, using nationally recognized wraparound approaches to meet the clinical and functional needs of the target population. Further, all current and future services will adhere to Federal and national standards of care, and reflect the highest quality. We anticipate serving approximately 100 children in the target population, and their families, during year 2 of the grant project, with most referrals coming from the mental health and juvenile justice systems. We plan to add 100 youth in Years 3

– 6 with a total numbers served exceeding 500 by the end of the grant cycle, during which time the PBIS systems will be in high gear, and similar levels of referrals from the child-serving sector. It is our hope and intention that the number of referrals made by families, members of racial and ethnic minorities (providers and families), along with primary care professionals, will increase during this time. Ultimately, the SOC approach will be used to serve all youth with serious mental health needs, and their families, in Craighead County, and will then be extended to all counties in the 7- county service area.

2. Optional Services: In addition to the mental health services described above, Connections for Kids will provide the following optional services: 1) Comprehensive screening assessments to determine eligibility for SOC, provided on-site in schools, juvenile justice/courts, and at Mid-South Behavioral Systems. Screening assessments are strengths-and needs-based, utilizing Life Domains and consistent with wraparound best practices; 2) Cross-Agency training and technical assistance (based on a comprehensive T/TA planning process described previously) in the following areas: Collaborative leadership, family partnership, cultural competency in services and policy development, wraparound, best practice and evidence-based clinical interventions, implementation of individualized Care Plans, facilitation and management of individualized Care Teams, delivery of intensive Care Management, intensive home-based services, and intensive day treatment, therapeutic foster care and therapeutic group homes (caring for not more than 10 children), emergency services, crisis outreach, crisis intervention and respite care; Comprehensive PBIS training and coaching for Universal, Targeted and Intensive School Teams according to emerging national models and through an expert PBIS trainer; 3) Consultation and training/technical assistance that reinforce SOC practices (and not traditional practices) in the development of SOC managed care integration, strategic planning, cross-agency/family/community collaboration, fiscal management, MIS, personnel management, and project management; 4) Implementation of evidence-based clinical interventions, such as Cognitive Behavioral Therapy, Multisystemic Therapy, Treatment Foster Care, wraparound and PBIS; 5) Development and implementation of practices and interventions that are appropriate for racial and/or ethnic groups in our community and have the potential to eliminate disparities in mental health care; 6) Recreational activities such as those provided through the YMCA, after school activities that may include therapeutic martial arts courses, therapeutic horse riding, etc.; 7) Other mental health services determined to be necessary and appropriate to meet a critical need of the child or the child's family, related to the child's SED. Funding of these services will not take precedence over the funding of the array of required services described in the RFA.

3. Nonmental Health Services: Funds from the cooperative agreement will not be used to finance these services. However, it is important to address nonmental-health needs of children through comprehensive Care Teams and Care Plans. We will work within the local substance abuse prevention network (Crowley's Ridge Development Council) to identify needed services. The Community Collaborative will ensure linkages, coordination and agreement with other agencies, organizations, and providers in the community to help ensure that the following resources are known, understood, and accessible: educational, education transition, health, substance abuse treatment and prevention services, vocational counseling and rehabilitation, protection and advocacy (for all children in the target population/with SED and their families, and especially those in the foster care system) resources. The Collaborative will identify all literacy interventions specific for children with SED. It will ensure collaboration with the primary care system, including collaboration with family physicians, pediatricians, and public health nurses to include systematic procedure that primary care providers can follow to refer children/families to the SOC, and procedures for including primary care providers in individualized Care Teams utilizing wraparound processes. Memoranda of Agreement have been establish, and will be strengthened through a MOU during Year 1, with agencies and providers for delivery of service under Federal entitlement, including Title XIX, Title IV-A, Title IV-B, Title IV-E, EPSDT, and IDEA (see Appendix 1).

D. KEY SERVICE ACTIVITIES

1. Clinical interventions: Connections for Kids will ensure that children in the target population have access to the most effective clinical interventions. The SOC will implement evidence-based interventions such as Cognitive Behavioral Therapy, Multisystemic Therapy, and Treatment Foster Care within the construct of best practice wraparound approaches through individualized and comprehensive Care Teams and Care Plans. Youth entering the SOC will receive a comprehensive strengths- and needs-assessment utilizing Life Domains, to ensure the best possible 'goodness of fit' between the child, his/her family and the services and supports provided. The SOC will institute and disseminate nationally recognized best practice standards for: 1) integration of evidence-based interventions into the individualized Care Plan, 2) procedures for diagnostic and treatment planning that match the specific mental health needs of the child with the most appropriate treatment or combination of treatments, 3) making necessary adaptations to evidence-based interventions especially for local racial and ethnic minority populations. Further, the Collaborative will encourage implementation of state-of-the-art community-based treatments and address the training needs of clinicians with respect to evidence-based treatments and appropriate application of DSM-IV diagnostic categories. Therapeutic approaches will be individualized to ensure culturally appropriate services.

2. Care management services: Connections for Kids will ensure that all children offered access to the SOC receive Care Management that is tailored to their individual strengths and needs. Our Care Managers are trained service providers who will use wraparound best practice approaches to plan, access, coordinate and monitor services and supports for each child and family. We will ensure that each child in the SOC is provided the level of Care Management appropriate to their specific needs that will: 1) unify services and supports into one comprehensive Care Plan (e.g., one family/one plan/one team); 2) establish eligibility of the child and the child's family for any financial assistance and services under Federal, State, and local programs through family-friendly/clear screening and assessment processes; 3) reassess the strengths and needs of the child and the child's family at least monthly during the first 6 months of enrollment, more often as needed, and at least quarterly thereafter; 4) modify the individualized Care Plan to the changing strengths and needs of the child and the child's family apply an Unconditional Care approach; 5) provide the family with information on the extent of progress made toward the objectives in the individualized Care Plan. Further, we will ensure that Care managers work with no more than 10 children and their families (1:10 ratio) for those with the most severe SED, and that Care Managers work with no more than 15 children and their families (1:15 ratio) for those children with SED whose needs are less complex than those with sever needs, but who still require regular monitoring of the delivery of services and supports.

3. Individualized service plans: Connections for Kids will ensure that each child or youth served within the SOC has an individualized Care Plan developed by a Care Team comprised those persons who are important in their everyday lives, including such members as representatives of the family, family advocates, neighbors, extended family members, health care professionals, and representatives of child-serving agencies providing services, as well as others who have been requested to participate by the family and the child (unless clinically inappropriate). The Care Team is constructed with the family so that each family's particular priorities, concerns, and needs may be met. Team members work together with the family to develop, implement and monitor an individualized Care Plan based on the family's priorities, concerns, functional strengths and needs. Care Teams and resultant Care Teams are developed and implemented consistent with wraparound best practices, ensuring that the process and results reflect and honor the culture of the family. Utilizing Life Domains, the child and his families' strengths and needs are comprehensively identified, needs are then prioritized and addressed through individualized approaches that are measurable and relate to outcomes that are meaningful to the child and his/her family. All interventions in the Care Plan build upon the child and his/her families' strengths, promoting resiliency and a positive service experience. Care Plans are coordinated with services available under parts B and H of the IDEA, including consistency and coordination with the IEP. All interventions are also fully coordinated with services available through the U.S. DHHS, Administration of Children and Families – Family

Preservation and Support Program. Key components of the Care Plan and its implementation include a description of the need for services and supports, the recognition of existing strengths of the child and the child's family, development of objectives that meet the needs of the child and his/her family that build upon their functional strengths, development of a specific methodology for meeting the se objectives, provision of all necessary core mental health services, and of nonmental health services, as appropriate, which are linked together to affect seamlessness in the service experience. Every Care Plan has a proactive and reactive Crisis Plan to help avoid unnecessarily restrictive service responses. The lead agency responsible for Care Management services for each child and the child's family is clearly designated in the Care Plan. Care Plans are reviewed based upon the changing needs and circumstances of the child and his/her family. However, the plans will be reviewed at least monthly for children and their families within the first 6 months of entry into the SOC, and quarterly thereafter.

E. FAMILY INVOLVEMENT, YOUTH INVOLVEMENT/CULTURAL COMPETENCE

1. Family Involvement: In 1995 funding from the Arkansas Division of Mental Health Services provided the resources for the incorporation of the Arkansas Federation of Families for Children's Mental Health, Inc. (AFFCMH). The organization's single staff member facilitated advocacy efforts at the state level as well as providing referral services to parents across the state via a toll free phone line. An annual statewide family conference was held in the spring of each year. Support group meetings were held in 5 areas of the State coinciding with the Department of Human Services service area map. Resources were also utilized to support family participation in the national conference held annually by the FFCMH. A training manual for support to families participating in substance abuse treatment was developed and a series of trainings provided to these families. A support group was developed in Jonesboro but was unable to sustain when the AFFCMH lost funding in 2001. Families were critical for the success of our CASSP initiatives and remain critical to the success of this SOC. We will ensure that the SOC develops and incorporates practices of family involvement. Family members will be actively involved in all components of SOC, including planning, implementing and evaluation the Project. They will also be active participants and full partners in decisions about the care of their child and in decisions about SOC development and service provision for other children with SED and their families. This will be accomplished in several ways. 1) Creation of a local parent support organization, working closely with AFFCMH to create a local chapter. The AFFCMH maintains a volunteer board structure and has committed to working collaboratively with the SOC to develop family support services and a local family support organization; 2) In partnership with AFFCMH, we will design a full time equivalent position for a family member to serve as the key family contact (Family Coordinator) to advocate for other family members of children receiving services in the SOC, and outreach to family members of children not receiving services. The Family Coordinator will promote, support and oversee all family related activities. This individual will take a lead role in developing training for families and providers and project management, act as an advocate at the local, state and federal level, help identify funding streams for families and act as a consultant to the screening, assessment and evaluation processes. This individual will be a full partner on the Community Collaborative, and will be actively supported to take leadership roles; 3) Pam Marshall, Federation of Families representative and key consultant to the project will train the Family Coordinator and initial board for the local family organization. 4) She will also recruit and train three Family Support Providers to work in coordination with the Care Manager staff. Family Support Providers will work one to one with families of children referred to the SOC to develop specific family support plans. Each family will have opportunity to participate in support groups, advocacy training; psychosocial education; training on mental health diagnosis; medications/side effects and positive behavioral interventions for their child. Family Support Providers will be trained to work closely with the PBIS evidence based approach adopted by the SOC; 5) Each Family Support Provider will have an active presence in the Parent Centers at each school in the target community. (As a result of the No Child Left Behind implementation Arkansas passed Ark. Stat. Ann. 6-15-702 which mandated the creation of Parent Centers in each school district and assignment of staff at each

building level to focus on parent involvement activities.) Family Support Providers will work with parent center staff to fully inform and engage parents of children referred to the SOC of activities promoted by No Child Left Behind.

We will ensure that compensation and fiscal support for families whose children are eligible for services, as well as for AFFCMH and the emerging local chapter. Through this support, we will enable family members and family organizations to participate in activities related to the development, implementation, and evaluation of the SOC. This support will also be provided for families and family organizations from racial or ethnic minority backgrounds in our community.

2. Youth Coordinator: The SOC will designate an individual to serve as youth coordinator in the SOC. Connections for Kids will employ this individual in a full time position. The Youth Coordinator will represent youth on the Community Collaborative as a full partner, and be supported to take a leadership role. He/She will be responsible for forming a support group for children/youth identified in the SOC as well as being an advocate for all youth receiving services and reach out to other eligible youth not receiving services. AFFCMH will work closely with the Youth Coordinator, ensuring support, access to all family support activities and benefits.

3. Cultural Competence: The SOC will ensure that all planning, development, implementation and evaluation activities of the Project are culturally competent, consistent with cultural competence standards, and abide by all Title VI guidelines from the Civil Rights Act. The Collaborative will utilize the services of Georgetown Cultural Competence Initiative through the National TA Center for Children's Mental Health to perform an assessment of needs for the target community and assist with development of a plan to address the needs during Year 1. The Collaborative will actively promote incorporation of culturally appropriate practices in all individualized Care Teams and Plans, e.g., using the preferred language of the child and family, nurturing their strengths and customs that are part of their cultural or religious heritage, and recognizing behaviors and beliefs that are normal in their culture. It will expand services available through the SOC to include service providers representing the racial and ethnic composition of the community, and plan for such service provision in the cultural context preferred by the child and family, without discrimination against the child or family on the basis of race, religion, national origin, sex, sexual orientation, disability, or age. Individuals representing the diverse cultures in the County will be invited to serve as advocates, to participate and take leadership roles on the Collaborative, Core Administrative Team, and Care Teams. We will provide evidence that the management plan, staffing pattern, project organization, and resources are appropriate and adequate for carrying out all aspects of the proposed project and are sensitive to issues of language, age, gender, sexual orientation, race, ethnicity and culture. We will ensure that disparities in access to care, quality of mental health services, availability of effective clinical interventions, satisfaction with services, and other SOC outcomes for children and their families from racial or ethnic minority groups are addressed.

G. SUSTAINABILITY/REPLICATION

Examples of successful demonstration or pilot sites are increasingly evident in communities and states across the country. However, few broaden their impact and last beyond initial funding periods. We will face this reality head on and address sustainability from the beginning. This will be accomplished by a two fold strategy; (1) bringing key players to the table and (2) addressing issues at not only the local level, but also the state level. In order for our SOC to sustain beyond the period of initial funding, every participant must engage in sustainability planning and implementation, developing at least a rudimentary understanding of funding and match requirements so that all potential fiscal opportunities are maximized. Recouping costs through Medicaid billing will be essential to our sustainability. In Arkansas, this may mean changes in reimbursement streams. Throughout the grant period, the Collaborative will work closely with the State, maximize all existing funding streams, demonstrate success that is directly attributable to the SOC to gain widespread support. A unique opportunity for replication is available since Mid-South Health Systems is the providing agency for a seven county area. After successful implementation in Craighead County, the SOC will expand to the remaining six counties in the service delivery area. We believe that early success will be critical to project success; the SOC

will start small, focusing on four school districts within Jonesboro, key portals in the community, and transition children back to their communities from out of home placements. Project activities will expand to the entire school district over the course of the grant. We expect that these approaches will become a model for replication and integration into other Arkansas counties.

SECTION C: PROJECT MANAGEMENT AND STAFFING

A. Applicant Organization: Mid-South Health Systems, Inc. (MSHS), is a 501(c)(3), not-profit organization, incorporated within the State of Arkansas, that provides comprehensive community-based behavioral health services to the residents of a primary service area comprised of seven counties within Northeast Arkansas. As well as to individuals who are referred for services from other services. MSHS is governed by a board of directors comprised of citizens representing the seven primary service counties served by the organization: Clay, Craighead, Greene, Lawrence, Mississippi, Poinsett, and Randolph. Since its establishment in the community, MSHS has long worked in a collaborative effort with the three primary partner agencies, the local schools, DCFS (Division of Children and Family Services), and the Juvenile Justice systems. The extended history of MSHS's collaboration with the local school districts has included providing school-based therapy, case management, and psychiatric evaluation for identified students, often at the school site. MSHS has also provided teacher training and evaluation services as requested. In addition, MSHS has a close relationship with DCFS through the therapeutic foster care program, where thirty-five beds are available to qualifying children. In order to address the chronic and extreme needs of these children a close collaboration with DCFS staff and MSHS is required. Furthermore, MSHS has established a relationship with the Juvenile Justice system to provide assessments, therapy, case management, etc., as needed to adjudicated children and youth. Also, MSHS provides psychiatric evaluation and on-going medication management for the youth housed at the residential treatment facility for adjudicated youth. Mid-South Health Systems also enjoys a working relationship with the local medical community, advocacy organizations, human service organizations, non-profit organizations. For example, MSHS has organized family support groups, provided on-going educational opportunities, and played a vital role in promoting good mental health in the seven county catchment area in collaboration with numerous organizations. The SOC will create a new organizational structure for agencies providing child and family services. Refer to the organizational chart in Appendix 6 for a full description. In addition, Memorandums of Understanding include commitments from the agencies involved.

B. Key Personnel: Key personnel will be responsible for day-to-day activities and operations of the Craighead County Connections for Kids. These personnel will comply with the goals and objectives of the Project in all activities. These personnel will include (1) Principle Investigator, and her assistant (2) Project Director, and her assistant, (3) Clinical Director, (4) Mental Health Professionals, (5) Care Managers, (6) Crisis Response Coordinators, (7) Evaluation Team, (8) Family Coordinator, (9) Family Support Providers, (10) Youth Coordinator, (11) Technical Assistance Coordinator, (12) PBIS Coach, (13) Redpoint Technician, (14) Communications Manager, (15) State and local agency liaison, and (16) Key Consultants. In addition to the information here, a Staffing pattern/Organizational chart is provided in Appendix 6.

(1) The Principle Investigator (Bonnie White, Executive Director, MSHS) will be responsible for the fiscal and administrative management and oversight of the Connections for Kids project. She will be legally responsible and accountable to the Arkansas Department of Behavioral Health. Ms. White's experience as Executive Director of Mid-South Health Systems has demonstrated her ability to manage this project (Please also refer to Ms. White's biographical sketch in Section G). Based on the scope of the project, it will be necessary for the Principle Investigator will dedicate 20% of her time (i.e., 8 hours per week) to this project.

(2) The Project Director (Marilyn Copeland) will be responsible for overseeing development of a comprehensive, strategic plan implementing the SOC within Craighead County, establish organizational structure, hire staff, and oversee the entire project. Ms. Copeland has demonstrated her experience and ability to fulfill the responsibilities as project director through

the management of the $9 million Safe Schools Healthy Students Initiative (Please also refer to Ms. Copeland's biographical sketch in Section G). Based on the many duties and responsibilities, the Project Director will be a full-time position with a full-time administrative assistant.

(3) The Clinical Director (Sharon Travis, LCSW) will oversee all clinical activities within to include hiring of staff, scheduling training, and participating in community teams. Ms. Travis has twenty-five years of experience in working with Children and families, and has been working for the last six years as Children's Service Director. (Please also refer to Ms. Travis's biographical sketch in Section G). Based on the many duties and responsibilities of the Clinical Director, the Clinical Director will be a half-time position with a full-time administrative assistant.

(4) Mental Health Professionals (unnamed) will provide assessment, diagnosis and individual/group/family therapy as indicated through Care Team activities. Mental Health Professionals will be housed in the schools, accessible via co-location to juvenile justice/courts and the local Department of Child and Family Services. Mental Health Professionals will have a Master's degree equivalent in Social Work, Counseling, or related field, licensed in the state of Arkansas to provide clinical services. Salaries will be budgeted for four full-time Mental Health Professionals by the end of Year 1 so that they may be intensively trained on the wraparound/CASSP/System of Care process. In the beginning of the second, third, and fourth years, salaries will be provided to increase the number of Mental Health Professionals by four each year to extend the service range of the Mental Health Professionals.

(5) Care Managers (unnamed) will be responsible for creating individualized Care Teams and Plans to serve the target population. Care Managers will work with families, schools, and other service providers, will facilitate Care Teams, and make sure that the family's needs are met (e.g., housing, glasses, medications, court appearances, school attendance, transportation, etc.) Care Managers will document services provided. Care Managers will co-lead Care Teams with family members. Care Managers will be Mental Health paraprofessionals with a Bachelor's degree in Social Work, Psychology, or related field, and who will have completed 40 hours of specialized training. In the end of the Year 1, salaries will be budgeted for eight Care Managers to be intensively trained on the wraparound/CASSP/System of Care process. At the beginning of the second, third, and fourth years, salaries will be budgeted to increase the number of Care Managers by eight each year to extend the service range of the Care Managers.

(6) The Crisis Response Coordinator (unnamed) will complete screenings and/or assessments of children within the county on an emergency basis., determine the best approach to ensure the child and community's safety, if hospitalization of the child would be necessary, or if respite services with families or temporary shelter would be more beneficial. The Crisis Response Coordinator will be a Master's Level Mental Health Professional licensed in the State of Arkansas. Based on the on-call, 24/7 nature of the position of the Crisis Response Coordinator, this position will be a full-time position.

(7) The Evaluation Team (led by David Saarnio, Ph.D.) will be responsible for all of the evaluation activities, including (1) conducting longitudinal studies of children/families served to measure the effectiveness of the SOC, (2) evaluating family satisfaction, (3) analyzing data from measuring tools (e.g., CAFAS, CBCL, etc.), and (4) report findings of local and National Evaluations to professional, research, and lay audiences through conferences and publications. The Evaluation Team will use existing resources to enter, store, manage, analyze, transmit and report data, and will share outcome results in a manner accessible by families, youth, agency personnel, and policy makers. The Evaluation Team will be housed in the Center for Social Research and Evaluation at Arkansas State University. The Center for Social Research and Evaluation includes four Ph.D. level- and one Ed.S. level-evaluator, as well as a number of graduate students. David Saarnio, the Director of the Center for Social Research and Evaluation has a Ph.D. in Developmental Psychology with additional expertise on statistics and evaluation. In addition, he has supervised evaluation activities on a number of recent grants (Please refer to Dr. Saarnio's biographical sketch Section G). Aaron Bolin and Robert Johnson each have a Ph.D. in Social Psychology, with varying experience in applied research and evaluation. Lisa A. Ochs, J.D., Ph.D., CRC, has background in law and rehabilitation counseling, as well as in applied research and advocacy. Across them, they have numerous publications and have

presented extensively at major research conferences. Christy Brinkley has an Ed.S. in Psychology and Counseling with an emphasis on School Psychology. She also has research and evaluation experience and has presented research findings at major conferences. Graduate students from the department of Psychology & Counseling at Arkansas State University will aid in the evaluating of the SOC. At least one parent/family member of a child with SED will be involved in the planning/implementation of the evaluation process of the SOC. The parent/family member will be an integral partner in evaluation. For example, he or she will (1) serve as a consultant, (2) assist with data collection (e.g., by leading focus groups, informal discussions with other parents, etc.) (3) provide feedback on the SOC development and the evaluation process, and (4) present evaluation findings to other families (e.g., through family meetings), etc. Based on the nature of the evaluation process, the equivalent of two full-time salaries will be provided to do the evaluation of the SOC.

(8) The Family Coordinator (Martha Lewis, parent of child with SED) will serve as key family contact, and be responsible for setting up and working with existing family organizations representing various diverse cultural and linguistic backgrounds of children and families in the County. The Family Coordinator will help establish a local chapter of the Federation of Families, organize local parents to ensure that the SOC serves the families, and serve as a representative on the Community Collaborative. In addition to having first-hand experience to the needs and problems that families with children with SED face, Ms. Lewis has served as a Parent Representative for the CASSP Program. Ms. Lewis has direct experience with navigating the currently complex and difficult service systems that impact her child's life as a result of his SED. (Please also refer to Ms. Lewis's biographical sketch in Section G). Based on the duties and responsibilities, the Family Coordinator will be a full-time position.

(9) Family Support Providers (unnamed) will be help families 1:1 to locate resources, develop communication skills, and problem solve. Family Support Providers will be advocates for the families on the Care Teams in conjunction with the Care Managers. Family Support Providers will work within the PBIS sites, be involved in the development of a local Federation of Families chapter, may lead parent support groups, assist with evaluation by providing feedback and presenting evaluation findings at family meetings, and help ensure family involvement in all aspects of designing, implementing and evaluating the SOC.

(10) The Youth Coordinator (unnamed) will represent youth with SED within grant activities and develop programs to facilitate youth involvement in the SOC. The Youth Coordinator will develop activities to address the needs of other youth with SED. We envision hiring a young (early twenties) person to fill this position, possibly recruiting from the local university. Based on the work to be done by the Youth Coordinator, this position will be full-time.

(11) The Technical Assistance Coordinator (Derek Spiegel, Ed.S., CRC, LPC) will serve as the central point within the SOC for strategizing and assessing the technical assistance needs of the project. The Technical Assistance Coordinator will be responsible for assessing the training needs of the Key Personnel, agency professionals, care team members, parents, and family members. He may also be involved in strategic and wraparound planning and in developing partnerships within the county. Mr. Spiegel's experience as CASSP Coordinator for Mid-South Health Systems, as a member of the State Executive CASSP Council, and as a clinical practioner with families in the community has provided a solid foundation for this position (Please also refer to Mr. Spiegel's biographical sketch in Section G). The Technical Assistance Coordinator will be a half-time position based on the duties that he will be performing.

(12) A PBIS (Positive Behavioral Interventions and Supports) Coach (unnamed) will facilitate implementing PBIS in each school building and district in the county through (1) global as well as specialized training at each school site for school staff, (2) troubleshooting activities, and (3) consultation services on an "as-needed" basis. The PBIS Coach will travel among the many school buildings throughout the eight school districts, and will serve in a full-time position.

(13) A RedPoint Technician (unnamed) will provide technical assistance in the use of this software program. RedPoint is a software program that will allow tracking PBIS information through the schools. The RedPoint Technician will oversee the implementation of this software, troubleshooting, and consulting with any of the schools in the eight districts on an "as-needed"

basis. The RedPoint Technician will also be traveling to the many school buildings throughout the eight school districts, and will serve in a full-time position.

(14) The Communications Manager (Jayni Blackburn and Matt Knight, Marketing and Information, Mid-South Health Systems) will develop a comprehensive social marketing strategy to educate the public about the SOC, and the impact of SED on the lives of children and families. The Communications Management Team, and Collaborative will ensure that marketing and will be culturally competent in addressing the diverse population in the County. Social Marketing and public education will be provided through diverse media including television, public service announcements, newspaper, Hispanic publications, and specially designed pamphlets, ongoing speaking engagements with civic and community groups. Through their extensive experience as the Marketing and Information Program for Mid-South Health Systems, Ms. Blackburn and Mr. Knight have developed marketing strategies to promote the mental health of children for seven counties (Please also refer to biographical sketches for Ms. Blackburn & Mr. Knight in Section G). Based on the marketing that will need to be developed for the SOC, one-quarter salaries will be provided for this team (10 hours per week for Ms. Blackburn and Mr. Knight).

(15) The State and Local Agency Liaison (Ann Wells, Deputy Director of Children's Services) will be responsible for coordination between the Department of Behavioral Health Services and Connections for Kids. The Liaison will also explore legislative changes within the state of Arkansas to ensure replication of the SOC throughout the state. Ms. Wells brings a wealth of experience in education, in addition to her current role as the Deputy Director of Children's Services. Based on the work to be done to ensure replication of the model created by the SOC, the Liaison will serve in a quarter-time position (25%, 10 hours per wee).

(16) Key Consultants will also be employed on an as-needed basis to provide training, consultation, and support with regards to specific needs of the SOC. Some of the Consultants that may be needed are trainers in PBIS, Red Point, SOC/Wraparound/CASSP, CAFAS, and Family Empowerment. Key Consultants will be employed on a contractual basis as needed.

C. Timeline of Activities:

Staffing Pattern Management Chart Timeline

Funding Year	Main Task	Person Responsible
Year 1	Develop Community Collaborative (governance board), initiate monthly meetings and activities	Bonnie White, Principle Investigator
	Hire Key Personnel	Community Advisory Board
	Train Key Personnel	Alice Baugh, Project Director
	Create Six-year strategic plan	Community Advisory Board Alice Baugh, Project Director Ann Wells, State Liaison
	Develop six-year technical assistance and training activities plan	Derek Spiegel, Technical Assistance Coordinator Alice Baugh, Project director
	Develop a plan to increase school and other site-based mental health services	Sharon Travis, Clinical Director
	Develop approach for services integration and coordination	Alice Baugh, Project Director Community Advisory Board
	Establish guidelines for Care Teams	Sharon Travis, Clinical Director
	Develop local chapter of the Federation of Families	Pam Marshall, Family Consultant Martha Lewis , Family Coordinator
	Implement activities for family involvement, youth	Pam Marshall, Family

	involvement and cultural competency	Consultant Martha Lewis, Family Coordinator Youth Coordinator
	Build the Capacity to enhance the National Evaluation	Dr. David Saarnio, ASU, The Center for Social Research and Evaluation
	Technical Training and assistance in the schools for the RedPoint software program	Red Point Consultant
	Train PBIS coaches	Marilyn Copeland, PBIS Coach
	Develop a Social Marketing Plan	Jayni Blackburn, Matt Knight, Social Marketing Team
	Work with Key Consultants	Marty Hydacker, Mental Health Pam Marshall, Family James Mason, Cultural Competency
Year 2	Hold Community Collaborative Meetings, related activities	Bonnie White, Principal Investigator
	Hire additional Care Managers, Therapists, etc.	Sharon Travis, Clinical Director
	Train new employees, and provide continuing education activities for existing employees	Alice Baugh, Project Director
	Implementation of the System of Care (i.e., Connections for Kids)	Alice Baugh, Project Director Sharon Travis, Clinical Director Derek Spiegel, Technical Assistance Coor.
	Begin to enroll children and their families	Alice Baugh, Project Director Marilyn Copeland, PBIS Coach Crisis Response Coordinator
	Incorporate Wraparound Model	Alice Baugh, Project Director Derek Spiegel, Technical Assistance Coordinator
	Incorporate families and youth into the evaluation process	Dr. David Saarnio, ASU Martha Lewis, Family Coordinator
	Implement RedPoint in First Cadre of schools	
	Implement PBIS in first cadre of schools	Marilyn Copeland, PBIS Coach
	Implement Social Marketing Plan	Jayni Blackburn, Matt Knight, Social Marketing Team
	Work with Key Consultants	Marty Hydacker, Mental Health Pam Marshall, Family James Mason, Cultural Competency
Year 3-6	Continue to hire additional staff.	Alice Baugh, Project Director Sharon Travis, Clinical Director
	Continue revision of the Connections for Kids as determined by local and National Evaluations	Dr. David Saarnio, ASU
	Incorporate Wraparound Model	Alice Baugh, Project Director Derek Spiegel, Technical Assistance Coordinator

	Incorporate families and youth into the evaluation process	Dr. David Saarnio, ASU Martha Lewis, Family Coordinator
	Implement RedPoint in First Cadre of schools	
	Implement PBIS in first cadre of schools	Marilyn Copeland, PBIS Coach
	Implement Social Marketing Plan	Jayni Blackburn, Matt Knight, Social Marketing Team
	Work with Key Consultants	Marty Hydacker, Mental Health Pam Marshall, Family James Mason, Cultural Competency
	Develop strategic plan for sustainability	Community Advisory Board Bonnie White, Principal Investigator
	Develop a plan for replication across the seven county mental health service area and throughout the state.	Community Advisory Board Bonnie White, Principal Investigator

D. Facilities, Equipment and Resources: The Service provision of the SOC will primarily occur in the schools and homes through Care Teams, led by the Care Managers. The Care Managers will be housed within the schools, and will be provided office space, equipment, access to copy machines, telephones, secretarial resources, etc. by the schools. Care Managers will also provide co-located services in juvenile justice/courts and in local Department of Child and Family Services. In addition, Therapists will be housed in the schools and provided with the same resources as the Care Managers. Administrative Staff (including the Principle Investigator, Clinical Director, and Communications Manager) will be housed at Mid-South Health Systems. Mid-South Health Systems will provide office space, access to telephones, copy machines, computers, etc. to these staff. Facilities for training, parent support group meetings, etc. will also be provided by Mid-South Health Systems. The Evaluation Team will be housed at Arkansas State University and will be provided with office space, computer hardware and software, telephone access, etc. to carry out duties in the evaluation process.

E. Accessibility of Services : Services will be provided primarily through the schools, with co-location services available in juvenile justice and in the local Department of Child and Family Services. Providing services in the schools families easier access to mental health services due to the schools' locations near their homes. In addition, Craighead County schools are already in compliance with the Americans with Disabilities, and are accessible to people with all levels of ability. Furthermore, providing services in the schools allows those children and parents of diverse backgrounds a common ground to receive services. Connections for Kids partner agencies recognize the need for cultural competency in all service provision and evaluation activities. To ensure cultural competency in service provision, all Connections for Kids staff will be trained in culturally competent service provision. Furthermore, every effort will be made to hire staff representative of the cultural diversity in the community. The evaluation staff will also ensure culturally competent data collection by using instruments that have been validated with diverse populations (e.g., CAFAS, CBCL). In addition, the Evaluation Team will consult with the College of Education Diversity Committee at Arkansas State University to ensure that all aspects of the evaluation process are culturally competent.

F. Privacy: Privacy and security of health information will be protected in compliance with HIPAA regulations. This protection covers all medical, mental health, substance abuse, and related information. Mid-South Health Systems is proud to employ a Corporate Compliance Officer who monitors and ensures that all confidential information remains in complete compliance with HIPAA regulations. For the Connections for Kids, all electronic files, case records, and evaluation data will be maintained in confidential records with access limited to

specific individuals. All reimbursement activities through electronic submissions, invoices, and any other means will also comply with HIPAA regulations, as is standard procedure for Mid-South Health Systems. Evaluation procedures will ensure privacy of those served by the SOC by assigning identification numbers to the data collected from each child and family (rather than using the names) and allowing access to the data to a very limited number of individuals.

SECTION D: EVALUATION PLAN

The newly formed Center for Social Research and Evaluation (CSRE) at Arkansas State University will be contracted to conduct evaluation activities for Connections for Kids. The CSRE will evaluate the Project throughout the 6-year federal funding period, working closely with the National Evaluators. The overall purpose of the evaluation will be to assess the effectiveness of SOC in meeting stated goals and objectives, as well as complying with the National Evaluation. We will focus heavily on (a) child and family outcomes, (b) implementation, development, and sustainability of the SOC, and (c) change in child and family outcomes that are directly attributable to the SOC.

Activities & Procedures: The CSRE will collect the following types of data: (a) child and family descriptive data, (b) diagnostic data (e.g., DSM-IV diagnosis), (c) symptomology data (e.g., various rating scales), (d) data on the functional status of the child at home, school, and in the community (e.g., CAFAS, CBCL), (e) data on the functional status of the family (e.g., living arrangements), (f) consumer satisfaction data (e.g., surveys, interviews), and (g) any other data needed for evaluation. These data will be obtained using various sources and methods, including data bases, interviews, focus groups, rating scales (e.g., CBCL, YSR), satisfaction surveys, and juvenile court data. Children, family members, educators, and mental health professionals will be involved in the data gathering process. During the first year of the grant, the CSRE will plan, organize, and finalize specific evaluation activities under the direction of the National evaluators, as well as obtain general baseline data so that a comparison to subsequent years can be made. During years 2 through 6, CSRE will collect data on each cohort of children for up to 3 years, independent of being served by SOC. In addition to the evaluation staff, caseworkers, clinicians, and family members will be involved in the data collection. Results of the data collection will be sent to the National evaluators on a quarterly basis. In addition to data collection and analysis, the CSRE will disseminate research and evaluation findings to various audiences, such as by submitting research to peer-reviewed journals and presenting at professional conferences.

National Evaluation: The CSRE will comply with the National Evaluation activities and provide data to them as needed, at least once per quarter. CSRE will also work closely with the National evaluators and use data from them to enable grant collaborators to (a) improve the Craighead County service system, (b) increase the quality of services provided to children and families in the target population, (c) develop SOC policies, and (d) sustain the Project beyond the 6-year period of federal funding. The National Evaluation and local evaluation activities will serve the purposes of holding the SOC accountable to stakeholders, helping to improve the quality of the Project, aiding in policy development, and providing information to aid in the sustainability and replication of the SOC.

Expertise of Evaluators: At this time, the CSRE includes four Ph.D. level- and one Ed.S. level-evaluator, as well as a number of graduate students. Therefore, there is a wealth of experience to draw from. David Saarnio has a Ph. D. in Developmental Psychology with additional expertise on statistics and evaluation. In addition, he has supervised evaluation activities on a number of recent grants. Aaron Bolin and Robert Johnson each have a Ph.D. in Social Psychology, with varying experience in applied research and evaluation. Lisa A. Ochs, J.D., Ph.D., CRC, has background in law and rehabilitation counseling, as well as in applied research and advocacy. Across them, they have numerous publications and have presented extensively at major research conferences. Christy Brinkley has an Ed.S. in Psychology and Counseling with an emphasis on School Psychology. She also has research and evaluation experience and has presented research findings at major conferences. Graduate students involved with the CSRE are from the department of Psychology & Counseling at Arkansas State University will also aid in the

evaluating of the SOC. In addition to the current members of the CSRE, a post-doc will be hired to aid in the evaluation of SOC. Also, parent members will be included in the evaluation by participating in a number of activities including consulting with evaluators, collecting data, conducting interviews, and reporting results of the evaluation.

Resources for Evaluation: Arkansas State University will provide office space for the evaluation staff to conduct the evaluation activities. In addition, the CSRE has a number of computers, databases (e.g., EXCEL, ACCESS), statistical packages (e.g., SPSS) and standard word processing programs (Microsoft Word and Corel WordPerfect).

How will functions be performed (data entry, etc): Precautions will be taken to ensure that all data gathered by the CSRE will remain confidential. One way this will be done is by assigning numbers to children instead of using their names. A master list of participants and their identifying numbers will be kept in a locked cabinet and will only be accessible by the evaluation staff. Data will always be entered using a child's identifying number instead of their name. All information will be kept secure (e.g., in locked filing cabinets, locked rooms, password protection for computers and files on computers).

Data Currently Available: CSRE has several resources available to them to coordinate a MIS for the SOC. During the planning stages of the grant (year 1), a survey will be conducted to determine current MIS among child-serving agencies in the area. The RedPoint System, a database that tracks several school variables, will play a crucial role in developing the MIS.

Involvement of Family Members and Youth : Family members and youth will be included in the evaluation activities of the Connections for Kids project in that they will help to obtain data (e.g., focus groups), provide feedback on evaluation procedures, serve as consultants, and report results to various audiences (e.g., other parents). Regular evaluation meetings will be held including CSRE members, parents, school staff, and mental health staff. Individuals who can help the evaluation process to be as culturally competent as possible will be invited to the meetings.

Local Activities: As part of the local evaluation, the CSRE will monitor SOC in meeting stated goals and objectives. This will be done using a variety of methods, including keeping attendance at family meetings, tracking the number of students identified as having SED, and obtaining important records from the mental health centers, schools, and juvenile office. In each step of the local evaluation, as well as the overall evaluation, the CSRE will work closely with individuals in all areas of the Connections for Kids project.

IRB: The CSRE will inform and seek approval from the Arkansas State University Institutional Review Board (IRB) regarding the intended activities for the evaluation of the Project. The CSRE will work closely with the IRB to ensure that all clients and staff are protected from risk, privacy and confidentiality are maintained, and that consent is obtained before any evaluation is conducted. A clear risk is a threat to privacy and confidentiality. However, every effort will be made to ensure that all information is protected in that it will be kept secure (e.g., in locked filing cabinets, locked rooms, password protection for computers and files on computers). Additionally, all data gathered will be coded with identifying numbers so that no names will be associated with responses and only the evaluation staff will have access to the master list.

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Craighead County Community Connections
Budget Justification
Personnel

Principal Investigator- Responsible for the fiscal and administrative oversight of the cooperative agreement, and is the official responsible and accountable to the funded community for the proper conduct of the cooperative agreement.

Project Director- Responsible for overseeing the development of a comprehensive strategic plan for creating and implement the proposed system of care; establishing the organizational structure; hiring staff; and providing leadership in all facets of the development of the system of care. Specifically, will direct the planning and development of Craighead County Community Connections; monitor recruitment, selection, and retention of children and families; monitor contractual agreements with consultants; and supervise a multidisciplinary staff.

Clinical Director- Responsible for interagency coordinated case management planning and implementation. Oversees the development of interagency management information system. Works with Mobile Assessment Teams, families, and children to develop individual service plans. Provides mental health assessments and oversees the role of Mobile Assessment Teams, as well as monitors the quality of the child and family assessment process. Facilitates family therapy sessions and crisis interventions.

Key Family Contact- Responsible for either setting up or working with an existing family-run organization that represents the cultural and linguistic background of the target population. Works in partnership with the project staff in all aspects of implementing the system of care and providing support services for families receiving services through the cooperative agreement.

Youth Coordinator- Responsible for liaising between youth who have a serious emotional disturbance and staff who are charged with the programming and implementation of the system of care. Also creates programs for young people to facilitate their involvement in the development of the system of care.

Technical Assistance Coordinator- Responsible for strategizing and assessing the technical assistance needs of the system of care, and is the primary link with the Technical Assistance Partnership for accessing the appropriate technical assistance. Technical assistance areas may include culturally competent practices and services, leadership, partnership/collaboration, strategic planning, wraparound planning, sustainability, family involvement, and youth involvement.

Social Marketing - Responsible for developing a comprehensive social marketing/communications strategy for the project community, including a social marketing strategic plan, public education activities, and overall outreach efforts.

State and Local Agency Liaison- Responsible for bridging efforts by the State and the target community to create a single system of care that will be sustained through collaborative and integrated funding investments from State and/or community-based child- and family-serving public agencies. Works to establish interagency involvement in the project's structure and process by developing and/or changing interagency agreements and other public policies relevant to the creation of the system of care.

Red Point Tech – Will coordinate the Red Point System that tracks and monitors the services and movement of students from school district to school district.

Clinical Positions – These positions include: Therapists and case managers, and are generally self-explanatory. All clinical positions are responsible for developing and implementing a child's mental health treatment plan per their specific discipline and according to each child's needs.

Clerical Positions – the Administrative assistant and clerical staff member will be responsible for maintaining client records and other general clerical duties.

Travel – Mileage Reimbursement - Local travel will be provided to case managers and therapists for use of their personal vehicles while traveling to participants' homes and between schools.

Fringe Benefit Rate

The fringe benefit rate is established based on the average per employee in the current FY budget. This includes FICA at 7.2% of salary, retirement contribution of 10% of salary, SUTA, Worker's Compensation, Health Insurance premium $299.80 per month per employee, Dental Insurance, Life Insurance and short term disability.

Contractual Costs

The Arkansas State University Center for Social Research and Evaluation, a State affiliated agency, will develop, establish and implement all aspects of the evaluation piece of this project.

The Positive Behavioral Interventions and Supports (PBIS) will promote increased school and community capacity to meet the needs of children and families with students who are, or may be at risk of emotional and behavioral disabilities. This contract will pay the PBIS coordinator and substitute teacher salaries as well as provide a BPIS Coach Trainer, travel for the trainer and PBIS supplies.

The Arkansas State University School of Social Work will include the PBIS process in its curriculum. This contract pays for one professor FTE.

The Red Point contract is to develop an automated data collection and access control system to satisfy the requirements and obtainable goals of the PBIS.

The following Key Consultants will be retained and their travel expenses covered:

Family Consultant – Pam Marshall
Mental Health Consultant – Marty Hydecker
Family Coordinator consultants – TBH
Cultural competency Consultant – James Mason
Arkansas Federation of Families for Children's Mental Health

Maintenance and Operations – Professional liability coverage for clinical staff will be provided.

Equipment

Computers will be purchased for all therapists and one computer for each 4 case managers to allow for proper documentation of treatment. In addition, computer hardware and software will be purchased in order to enter, store, manage, analyze and transmit data; analyze, interpret and report results of the evaluation process.

Training – SAMHSA Conference, 10 staff will be sent to 3 three day conferences. This line item includes airfare, meals and lodging.

Systems of Care Conference, airfare, meals and lodging for 2 staff for 4 days and 3 nights.

Social Marketing - Brochures describing the project will be designed, purchased and distributed through out the districts. Supplies and promotional items will distributed to teachers, juvenile justice workers and social service agencies in an effort to educate the community. Newspaper and television advertising will be purchased for the CCC Connections project.

Flexible Funds – Wraparound funds for non mental health services or goods purchased to support the functioning of the child and/or the family. Examples include respite care, tutoring, one on one aid in the classroom, athletic fees or supplies.

Indirect Cost Rate

There is not currently a Federally approved indirect cost rate. We are in the process of obtaining a rate and hope to include it up to 2% in future years.

JOB DESCRIPTION

POSITION TITLE: Principal Investigator

REPORTS TO: Community Collaborative Board

SUPERVISES: Craighead County Connections for Kids (CCCK) Staff

DATE WRITTEN: October 5, 2003

SUMMARY:
The Principal Investigator has the overall responsibility for the management of CCK. Plans, directs, or coordinates operational activities at the highest level of management with the help of subordinate directors. This position reports directly to the Community Collaborative Board.

DUTIES:

- Responsible for the fiscal and administrative oversight of the cooperative agreement.
- Responsible and accountable to the funded community for the proper conduct of the cooperative agreement.
- Responsible for or will designate someone for liaison with State officials and agencies.
- Responsible for the development and monitoring of the annual budget.
- Insures that CCCK is in compliance with the appropriate state and federal guidelines.
- Responsible for ongoing review and assessment of the Project.
- Responsible for long and short term goals and objectives of the project.
- Provides leadership to staff.
- Any special duties assigned or delegated by the Community Collaborative Board.

KNOWLEDGE/EXPERIENCE:
Knowledge of State and Federal guidelines governing the operation of a Community Mental Health Center in the State of Arkansas. A minimum of five years of responsible upper management experience in a health care setting, preferably a mental health setting. Experience in developing and monitoring a budgetary process. Demonstrated experience providing leadership to senior staff members. A thorough understanding of clinical practices and ethical boundaries governing mental health treatment.

Principal Investigator	Chairman, Community Collaborative Board
Date	Date

JOB DESCRIPTION

POSITION TITLE: Project Director

REPORTS TO: Principal Investigator

SUPERVISES: Craighead County Connections for Kids (CCCK) Staff

DATE WRITTEN: October 5, 2003

SUMMARY:
Under the supervision of the Principal Investigator and is responsible for the day-to-day operations of the CCCK Project.

DUTIES:

- Responsible for overseeing the development of a comprehensive strategic plan for creating and implementing the proposed system of care under the CCCK Project.
- Responsible for developing policies and procedures for the project.
- Oversees implementation of policies and procedures and monitors compliance.
- Responsible for hiring project staff.
- Monitors and evaluates staff.
- Monitor overall needs of the CCCK Project.
- Provide information and recommendations to Principal Investigator and Advisory Board.
- Represent the CCCK Project at community meetings, forums, etc.
- Special duties as assigned or delegated by the Principal Investigator.

KNOWLEDGE/SKILLS:
Excellent oral and written communication skills. Knowledge of wraparound process. Ability to work well with others. At least two (2) years supervisory experience.

EDUCATION/EXPERIENCE
At least a Bachelor's degree in social work, education or a related field. Prior experience working with grants is desirable.

Project Director	Principal Investigator
Date	Date

JOB DESCRIPTION

POSITION TITLE: PBIS Coach

REPORTS TO: Project Director

DATE WRITTEN: October 5, 2003

SUMMARY:
Under the supervision of the Project Director and primary responsibility will be to promote increased school and community capacity to meet the needs of children and families with students who are, or may be at-risk of Emotional and Behavioral Disabilities.

DUTIES:

The PBIS Coach will provide and assist building level participants to PBIS coaching strategies which will include:

- Procedures to prepare, support and guide schools in implementation of school-wide, targeted and intensive interventions.
- To develop data analysis skills to assist schools in organizing, collecting, and analyzing PBIS data at school-wide, targeted and intensive levels.
- Learning skills and supports to train and evaluate multiple schools and districts progress with implementation of PBIS for sustainability over time.

Knowledge/Skills:
Person should have excellent written and oral communication skills. Should have experience in implementation and development of school-based mental health services and have served on a variety of community collaborations.

PBIS Coach	Project Director
Date	Date

JOB DESCRIPTION

POSITION TITLE: Marketing and Education Director

REPORTS TO: Project Director

SUPERVISES: Marketing Staff

DATE WRITTEN: October 5, 2003

SUMMARY:

Under the direct supervision of the Project Director and is responsible for all Public Relations and Marketing activities.

DUTIES:

- Responsible for developing a comprehensive social marketing strategy that will educate the public about the Craighead County Connections for Kids Project.
- Responsible for developing marketing strategy that will educate the public about the impact of SED on the lives of children and their families.
- Write, edit and prepare information for publication and information packets. Appears for radio/tv interviews as requested.

SKILLS/KNOWLEDGE:

Excellent oral and written communication skills. Excellent organizational and creative skills.

EXPERIENCE:

Bachelors Degree in Public Relations, Marketing, Journalism or a related field and/or extensive experience in public speaking and writing for publication.

Marketing/Education Director	Project Director
Date	Date

JOB DESCRIPTION

POSITION TITLE: Technical Assistance Coordinator

REPORTS TO: Project Director

DATE WRITTEN: October 5, 2003

SUMMARY:

Under the general supervision of the Project Director, coordinates all CCCK services for Craighead County.

DUTIES:

- Coordinates development of regional and county CCCK team/services.
- Attends and participates in statewide CASSP Coordinating Council meetings and maintains documentation of activities.
- Assesses technical assistance needs of the community, which may include providing information related to cultural competence, effective partnerships, strategic planning, wraparound, etc.
- Performs other duties as assigned.

KNOWLEDGE/SKILLS:

Requires specific knowledge in reference to CASSP legislation, care management, and wrap-around services. Requires the ability to work effectively with other children's service providers.

EDUCAITON/EXPERIENCE:

Three (3) to five (5) years of provision of clinical services to children/adolescents. Licensed as Mental Health Professional in the State of Arkansas.

Technical Assistance Coordinator	Project Director
Date	Date

JOB DESCRIPTION

POSITION TITLE: Red Point Tech

REPORTS TO: Project Director

DATE WRITTEN: October 5, 2003

SUMMARY:
Under the supervision of the Project Director, the Red Point Tech will be responsible for working with county school district personnel to insure the development of a complete and successful PBIS data tracking system.

DUTIES:
The Red Point Tech will be responsible to provide the following services:

- Initial consulting services to actively participate in the discovery process and define the requirements and best solutions for meeting the required PBIS data.
- Development and installation of any software solutions defined as a result of the discovery and requirement process.
- Installation and integration of any hardware purchased for the use with the delivered software.
- Provide training and technical support for all Red Point supported software and hardware.
- Will hold regular workshops with Technology Directors from each school district in Craighead County.
- Will provide on-site training and technical assistance to each school district at the building level.

KNOWLEDGE/SKILLS
Possess excellent written and verbal skills. Be familiar with the Red Point System and with APSCN (Arkansas Public Schools Computer Network) system.

Red Point Tech	Project Director
Date	Date

JOB DESCRIPTION

POSITION TITLE: Clinical Services Director

REPORTS TO: Project Director

SUPERVISES: Clinical Staff

DATE WRITTEN: October 5, 2003

SUMMARY:

Under the general supervision of the Project Director, coordinates the delivery of clinical services to identified clients.

DUTIES:

- Supervises all clinical staff, including therapists and care managers.
- Assesses training needs for clinical staff and provides information regarding best practices.
- Coordinates client care with other provider agencies.
- Attends care team staffings as indicated; conducts clinical staff meetings.
- Performs other duties as assigned.

KNOWLEDGE/EXPERIENCE:

Licensed as a Mental Health Professional in the State of Arkansas. Two(2) years experience required in supervisory/management position.

Clinical Director	Project Director
Date	Date

JOB DESCRIPTION

POSITION TITLE: Care Manager

REPORTS TO: Clinical Director

DATE WRITTEN: October 5, 2003

SUMMARY:
Under the direction of the Clinical Director, provides care management services to clients as assigned.

DUTIES:

- Provides care management services which include coordination of client treatment, referral and assistance in meeting basic family needs, parenting education and support, development and implementation of behavior management techniques, collaboration with other providers, etc.
- Completes required documentation including progress notes, correspondence, other paperwork as indicated.
- Participates in care team staffing/other meetings as indicated.
- Performs other duties as assigned.

KNOWLEDGE/SKILLS:

Must have knowledge of behavior management techniques, knowledge of community resources, excellent oral and written communication skills, strong organizational skills, and the ability to work with a challenging client population.

EDUCATION/EXPERIENCE:

Bachelor's degree in social work, psychology, or a related field. Prior experience working with children/adolescents is desirable.

_____	_____
Care Manager	Clinical Director
_____	_____
Date	Date

JOB DESCRIPTION

POSITION TITLE: Mental Health Professional

REPORTS TO: Clinical Director

DATE WRITTEN: October 5, 2003

SUMMARY:
Under the supervision of the Clinical Director, provides clinical services to clients.

DUTIES:

- Provides direct services to clients which may include intake assessment; individual, group, or family therapy; family education and support, etc.
- Completes master treatment plans, treatment plan updates, progress notes, APS registration, and other paperwork as indicated.
- Participates in care team staffings/other meetings as indicated.
- Performs other duties as assigned.

KNOWLEDGE/SKILLS:

Knowledge of psychotherapeutic techniques; ability to establish and maintain rapport with clients; ability to assist clients in establishing treatment goals and in working to accomplish the same. Excellent oral and written communication skills.

EDUCATION/EXPERIENCE:

Licensed as a Mental Health Professional in the State of Arkansas. Prior experience working with children/adolescents is desirable.

Mental Health Professional	Clinical Director
Date	Date

JOB DESCRIPTION

POSITION TITLE: Crisis Response Coordinator

REPORTS TO: Clinical Director

DATE WRITTEN: October 5, 2003

SUMMARY:
Under the general supervision of the Clinical Director, coordinates the provision of mobile crisis services for the Craighead County Connections for Kids Project.

DUTIES:

- Will complete screenings and/or assessments of children within Craighead County on an emergency basis and determine the best approach to ensure the child and community's safety.
- Provides day crisis call coverage.
- Will link child to appropriate treatment facilities and provide appropriate follow-up.
- Will recruit and train other crisis team members.
- Will ensure scheduling of crisis team members.
- Provide 24-hour coverage for all on-call screeners.
- Follow up on all screenings completed by other crisis team members to ensure quality of care.
- Will provide technical assistance to law enforcement, local hospitals, schools, public and private agencies requesting emergency services.

SKILLS/KNOWLEDGE:
Knowledge of behavior management techniques, knowledge of community resources, excellent oral and written communications skills, excellent organizational skills and the ability to work with a challenging client population.

EDUCATION/SKILLS:
Master's Level Mental Health Professional licensed in the State of Arkansas. Previous experience working with children and adolescents would be beneficial.

Crisis Response Coordinator	Clinical Director
Date	Date

JOB DESCRIPTION

POSITION TITLE: Youth Coordinator

REPORTS TO: Clinical Director

DATE WRITTEN: October 5, 2003

SUMMARY:
Under the general supervision of the Clinical Director, acts as a liaison between youth and staff who are developing and implementing system of care in Craighead County.

DUTIES:

- Serves as liaison between youth who have a serious emotional disturbance (SED) and staff who are charged with the development and implementation of a system of care.
- Develops programs and activities for young people to facilitate their involvement in the development of a system of care.

KNOWLEDGE/SKILLS:
Good written and oral communication skills. Works well as a team member.

EDUCATION/EXPERIENCE:
Desire to work with children and adolescents who have a serious emotional disturbance.

Youth Coordinator	Clinical Director
Date	Date

Family Support Director
Job Description

Responsibilities:
This position will be responsible for the overall direction of the Craighead County Family Support Program. The position will provide oversight and management for the program including supervision of family support provider staff in coordination with the care managers of the Craighead County Connections for Kids Project (CCCK). This position will provide technical assistance regarding family involvement to the CCCK Project and will work with the Technical Assistance/Social Marketing Coordinator in meeting specific technical needs of the project. The position will work with the Youth Coordinator of the CCCK Project to develop and sustain youth voice in system reform.

Duties:
- Supervise Family Support Providers to work in coordination with care management staff of the CCCK Project
- Develop training curricula for families, providers and project management
- Participate in core project management team to ensure project goals are met
- Participate in monitoring and evaluation of the project
- Participate in local and statewide committees or advisory boards or provided suitable representation
- Participate in meetings with national project staff
- Develop regular reports on program activities
- Present information on the project to community groups and national project staff
- Other duties as they arise.

Experience and Skills:
The person in this position must have experience as a parent or caregiver of a child with a serious emotional disturbance or disability with multiple agency involvement. Experience with business office management; program development across multiple systems and agencies; a record of working across diverse populations with and for families; staff supervision; training and public speaking skills are also considered.

Accountability:
The person in this position is directly supervised by and accountable to the Board of the Craighead County Family Support organization. The person in this position is also accountable to the CCCK Project management team for program related activities.

CONFIDENTIALITY/SAMHSA Participant Protection

1. Protection from Potential Risks:

There are minimal risks involved in this project. Physical, medical, psychological, social, legal, or other risks are not likely. Breach of confidentiality may provide the greatest risk: however all precautions will be taken to ensure confidentiality will be maintained. For example will comply with all HIPAA regulations. There should be no risks or adverse effects due to participation in the project. The activities and services provided in this project are designed to improve and support the functioning of the child and family. The evaluation staff will also comply with procedures for maintaining confidentiality. For example, children's names will be separated from the data in datafiles.

2. Fair Selection of Participants:

The target population for Connections for Kids is children and youth:

- Ages 5 to 18, as well as those who are between 18 and 21 when enrolled in the project prior to age 18; and,
- Who have an emotional, behavioral, or mental disorder under DSM-IV or its ICD-9-CM equivalents, or subsequent revisions, including those with a co-occurring SED and Substance Use Disorder (SUD); and,
- Who have a disability that must have been present for at least one year, or, on the basis of diagnosis, severity, or multi-agency intervention, be expected to last more than one year; and,
- Who are unable to function in the family, school, or community, or in a combination of these settings as measured by a total score of 140 on the Child and Adolescent Functional Assessment Scale (CAFAS); OR whose level of functioning is such that the child/youth requires multi-agency intervention involving two or more community service agencies providing services in the areas of mental health, education, child welfare, juvenile justice, substance abuse, and primary health care.

For those youth who enter the project by age 18, the requirement described in item four, above, will include community service agencies that provide services in the areas of adult mental health, social services, vocational counseling and rehabilitation, higher education, criminal justice, housing, and health. It is also critical that families be involved discussions about every element of service provision to accommodate their needs and backgrounds. There is no intention to target homeless youth, pregnant women, or other special groups. However, we will not exclude services for those children in special circumstances (e.g. foster care).

It needs to be noted that children, including those with mental disabilities and some from institutions, will be part of the target population The involvement of such children is inherent in targeting children with SED. All children with SED have a potential to be involved in this project. Children will be excluded if they do not fit the classification for SED found in the DSM IV TR.

Participants will be selected through four portals: Education, Department of Children and Family Services, Juvenile Justice and Mental Health. Thus the referrals may come from a variety of sources. Selection will be based on an initial screening to ensure that each participant meets the criteria for inclusion in the project. This screening will be conducted by a clinician licensced in the State of Arkansas.

The **geographic service boundary** for the CC Connections for Kids is Craighead County, (which includes the city of Jonesboro), Arkansas. Based upon ARKids Count CLIKS (County-City-Community Level Information on Kids--CLIKS), there are 19,809 children in Craighead County. Currently, there are 14,285 children between 5 and 18 enrolled in county schools (Jonesboro Sun). A few hundred children are either being home schooled or have left the school system, but there are no official numbers of these children. Although the demographics are changing, the current estimates are that, of all school children, 83% are white, 11% are black/African American, 3% are Hispanic, and 1% are Asian. There are very few American Indian/Native Alaskan children. Tremendous variability exists across school districts in the county. For example, one of the small, rural school districts has seen an influx of poor and Hispanic migrant students (who now account for 25% of that population). From the 1990 to the 2000 census, the Hispanic population of Craighead County grew by 350% (IEA Census State Data Center).

Based on the national prevalence rates of SED, we estimate that Craighead County has close to 1000 children with SED (14,285 in schools x median prevalence 07% = 999.95 children) that could be reached through the schools if there were a systematic approach to identifying them. According to the CASSP report (CASSP report, 2002), early intervention for children/youth with SED is sorely needed. A method that would allow these 1000 children to be identified and assisted is absolutely necessary. Co-morbidity is also a problem in Craighead County. When compared with national averages, data indicate that students from the Jonesboro community have a higher prevalence of drug use than their peers. For example, of 12th-graders in Craighead County, 25% have tried some kind of drug, and 33% are heavy alcohol users (CLIKS–2002 data).

3. Absence of Coercion:

Participation in this project is voluntary for children and families. However, it may be possible that a child may be ordered by the court to participate in the project. There are no potentially coercive elements are expected. All participants in the Connection for Kids Project will receive service after inclusion in the project regardless of their willingness to cooperate with evaluation activities.

4. Data Collection:

All data collected will focus on psychosocial information rather than physical specimens. Data will be collected from the children participating in this project, and from their family members, and staff from participating agencies (schools, mental health, social services, juvenile justice). The specific instruments and timing of data collection will be determined by the National Evaluation project staff. Data from interviews and focus groups will likely be collect at the county schools. Expected data collection instruments are provided in appendix three. Additional instruments and interview protocols will be developed during the planning year of the grant.

5. Privacy and Confidentiality:

All state statutes and Arkansas Division of Behavioral Health Services rules and regulations, as well as all HIPAA regulations will be followed for the protection of confidentiality. Participants will receive a full explanation of the project purposes and instruments to be used. Their informed consent will be obtained before any program evaluation is done. A system of unique non-disclosing identifiers is used in lieu of names and reporting information. Participation in evaluation activities is voluntary; provision of services does not depend upon participation in the evaluation. Staff receive careful training in non-disclosure procedures. If co-morbidity includes alcohol or drug issues all client records will follow federal provisions.

6. Adequate Consent Procedures:

Connections for Kids will ensure the protection of an individual's rights to confidentiality, and informed consent, including a description of the role of the legal guardian. Methods of documenting consent that are employed include reading the consent forms to individuals who are then questioned to assure their understanding of the consent agreement and for what purpose it will be used. They are then given copies of the consent forms. An interpreter will be provided when appropriate.

All participants and families will be told the following:

- Their participation is voluntary
- They have the right to leave the project at any time without problems
- Potential risks will be fully explained
- Children and families will be told that they will be protected from risks in every way possible

For youth identified for inclusion in the project, parental written informed consent and child informed assent will be obtained. Those with limited English or reading skills, assistance will be provided (e.g., consent forms will be read when necessary, and participants will be asked questions to ensure their understanding). A sample consent form is given in Appendix 4; the form will be modified as needed during the planning year. Consent for participation in the project will be solicited periodically across different parts and stages of the project. Participation in Connections for Kids services is not dependent on provision of evaluation data.

7. Risk/Benefit Discussion:

As there are no identifiable adverse effects, and comprehensive, mandated procedures are in place to protect children and families in their participation in services through the project, risks are quite minimal. However, the benefits of participation in the System of Care are considerable in promoting success and well being for children and their families. Thus the minimal risks involved are small compared to the benefits for individual children, families, and society.

MEMORANDUM OF AGREEMENT

CREATING A SYSTEM OF CARE APPROACH FOR OUR CHILDREN AND THEIR FAMILIES IN CRAIGHEAD COUNTY, ARKANSAS

Purpose of Agreement

We agree to work together to implement a System of Care approach for our children and their families in Craighead County. To this end, we agree to work together as full and equal partners to create neighborhood and community environments in Craighead County that empower and support these children and their families to reach their full potential as responsible, productive and caring individuals.

The MOA partners will develop a System of Care approach adhering to the following core values and guiding principles:

Core Values

1. Services and supports provided for children and their families should be child centered and family focused, with the needs of the child and family dictating the types and mix of services and supports provided;
2. Services and supports should be neighborhood and community based, with the locus of services, supports, and decision-making responsibility regarding these resting at the local level;
3. Services and supports should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic strengths and differences of the children and families they serve.

Guiding Principles

Children and their families should:

1. Have access to a comprehensive array of services and supports that advance strengths and address physical, emotional, social, spiritual, and educational needs;
2. Receive individualized services and supports in accordance with their unique strengths, needs and potentials, guided by one integrated and individualized service plan;
3. Receive services and supports within the least restrictive, most normative environment that is appropriate and safe;
4. Be full participants in all aspects of the planning and delivery of their services and supports;
5. Receive services and supports that are integrated, linked among agencies and providers and promote common mechanisms for planning, developing, and coordinating services;
6. Be provided case management or similar mechanisms to ensure that multiple services and supports are delivered in a coordinated and therapeutic manner so that movement through the system of services and supports responds to their changing needs;
7. Have the benefit of prevention, early identification and intervention to enhance the likelihood of positive outcomes;
8. Have their rights protected through effective advocacy;
9. Receive services without regard to race, religion, national origin, gender and sexual orientation, physical disability, or other characteristics, with services and supports that are sensitive and responsive to cultural differences and unique needs.

Implementation of Agreement

We agree to work together to build an array of services, supports and linkages among the public agencies, families, their neighborhoods and communities that is responsive our children and their families through the following activities:

1. Empower our representatives in existing collaborative entities to implement System of Care approaches, in accordance with SOC values and principles. Develop genuine, equal and supportive partnerships among all local collaborative entities;
2. Actively promote the participation of family members in all local collaborative entities, and cultivate effective parent and service provider partnerships through other formal and informal strategies;
3. Work together to identify common goals and promote the development of a common language that both child-serving professionals and parents understand;
4. Provide individualized, comprehensive, community-based, culturally responsive and family driven services/supports through our respective agencies, organizations and resources;
5. Integrate existing services and supports with other identified resources;
6. Actively support the evaluation of service outcomes in order to inform decision-making and improve service delivery and processes that involve families receiving services;
7. Share training information and promote cross-agency/provider/family training activities that support the development of System of Care approaches;
8. Maximize existing resources and develop sustainable funding strategies among public agencies;
9. Actively promote the development of protocols to review the needs of children and families receiving services from multiple agencies to establish effective, accessible and integrated services and supports, and to reduce duplication of effort;
10. Work together to seek and share new resources in support of this MOA;
11. Actively promote public awareness and community support for a collaborative System of Care approach.

Scope of Agreement

It is understood that while each of the agencies represented in this agreement have well defined duties and responsibilities that are mandated by State and Federal Law, this agreement is not intended to and shall not diminish responsibility or supplant the existence of services or authority of the participating agencies.

This agreement is intended to be a living document that reflects the intentions of the City of Jonesboro, Arkansas, its agencies, and its community partners to work together to develop a community-based System of Care approach. Comprehensive services and supports for our children and their families require broad and ongoing family, neighborhood and community partnerships. Other partners are encouraged and invited to join in this agreement as desired.

This Memorandum of Agreement is hereby executed by the individuals listed below:

Exec. Director, Mid-South Health Systems

Craighead County Superintendents' Assn.

Craighead County Judge

Craighead Co. Juvenile Probation Office

Second Judicial Circuit Judge

Craighead County Dept. of Human Services

Craighead Co. Div. of Children/Family Serv.

Craighead Co. Div. of Developmental Disability Services

Craighead County Health Department

Craighead Co. Rehabilitation Services Manager

Vice-Chancellor of Research & Technology Transfer

Federation of Families

Local Parent Coordinator

Director, Div. of Behavioral Health Services

Alice Baugh

LETTER OF INTENT

The **City of Jonesboro, Arkansas (City)** is applying to the *Substance Abuse and Mental Health Services Administration* under RFA SM03-009 for a cooperative agreement for the development of a "systems of care" in Craighead County, Arkansas, that will deliver effective, comprehensive community mental health services to children and adolescents in the county who have a serious emotional disturbance and their families. In anticipation of this award, the City has designated ***Mid-South Health Systems, Inc. (Mid-South),*** Administrative Agent for the City, as subcontractor for the planning and implementation of the **Craighead County Connections for Kids Project (CCCK).**

This Letter of Intent sets forth the understanding between ***Mid-South Health Systems*** and the ***City of Jonesboro, Arkansas,*** whereby, the City of Jonesboro will fulfill certain Award obligations. More specifically, they intend to:

- Designate Mid-South Health Systems as administrator of the cooperative agreement.
- Appoint two (2) representatives to the project's Community Collaborative Board.
- Fully cooperate in providing requested data for the national evaluation of the Comprehensive Community Mental Health Services Program for Children and Their Families.

Further, it is the intent of **Mid-South** to:

- Serve as Administrator of the cooperative agreement on behalf of the City.
- Provide directly any services required by the cooperative agreement.
- Provide office space for administrative staff to include utilities.
- Complete and submit all reports required by the cooperative agreement in a timely manner.
- Provide any matching funds required.
- Handle all financial obligations under the cooperative agreement and furnish the City Finance Director with monthly reports and an annual audit.

We, the undersigned, have participated in the development of the application for the Award and are committed to the development of a Comprehensive Family Centered System of Care in Craighead County, Arkansas and the objectives as set forth in the application.

Mayor, City of Jonesboro

Mid-South Health Systems, Inc.

Attested by:

City Clerk

LETTER OF INTENT

The **City of Jonesboro, Arkansas (City)** is applying to the *Substance Abuse and Mental Health Services Administration* under RFA SM03-009 for a cooperative agreement for the development of a "systems of care" in Craighead County, Arkansas, that will deliver effective, comprehensive community mental health services to children and adolescents in the county who have a serious emotional disturbance and their families. In anticipation of this award, the City has designated ***Mid-South Health Systems, Inc. (Mid-South),*** Administrative Agent for the City, as subcontractor for the planning and implementation of the **Craighead County Connections for Kids Project (CCCK).**

This Letter of Intent sets forth the understanding between ***Mid-South Health Systems*** and the **Public School Systems in *Craighead County, Arkansas*** whereby, the school systems listed below will fulfill certain Award obligations on behalf of Mid-South. More specifically, these eight (8) Craighead County school systems will pursue Award objectives and an enhanced system of care within Craighead County, Arkansas. More specifically, they intend to:

- Provide school-based office space for mental health case managers and therapists. This office space includes all utilities.
- Provide utilization of the school-based Parent Resource Centers for all parents to access educational and mental health related material and to utilize for parent support group meetings. The provision of this space will include all utilities.
- To provide PBIS Building Level Staff/Teams to develop and implement the PBIS discipline model. The teams will work under the leadership and training of the county-wide PBIS Coach that will be employed by the grant.
- Commitment to fully cooperate with evaluation staff to support the CMHS-funded National Evaluation activities and reporting requirements.
- Designate school district superintendent and/or their appointed designee to attend all Craighead County Connections for Kids (CCCK) Community Advisory Board meetings.

Further, it is the intent of **Mid-South** to:

- Provide office space for Craighead County Connections for Kids (CCCK) staff, including the Principal Investigator, Project Director, Clinical Director, Human Resources Director, Marketing Director, Parent Coordinator, Youth Coordinator, etc. This office space includes all utilities.
- Provide space for ongoing training, clinical staff meetings, family meetings, support groups, etc. This space includes utilities.
- Employ mental health case managers and therapists to provide mental health services for the schools in Craighead County.
- Provide clinical oversight/direction of CCCK through the employment of a Clinical Director and the support of two (2) Child Psychiatrists.
- Cooperate fully with evaluation staff, schools, and other public service agencies identified through CCCK.
- Designate appropriate mental health staff and/or their appointed designee to attend all CCCK Advisory Board meetings.

We, the undersigned, have participated with Mid-South and the City of Jonesboro in the development of the application for the Award and are committed to the development of a Comprehensive Family Centered System of Care in Craighead County, Arkansas and the objectives as set forth in the application.

Jonesboro Public Schools

Bay Public Schools

Nettleton Public Schools

Brookland Public Schools

Valley View Public Schools

Buffalo Island Central Schools

Westside Public Schools

Riverside Public Schools

Mid-South Health Systems, Inc.

LETTER OF INTENT

The **City of Jonesboro, Arkansas (City)** is applying to the *Substance Abuse and Mental Health Services Administration* under RFA SM03-009 for a cooperative agreement for the development of a "systems of care" in Craighead County, Arkansas, that will deliver effective, comprehensive community mental health services to children and adolescents in the county who have a serious emotional disturbance and their families. In anticipation of this award, the City has designated ***Mid-South Health Systems, Inc. (Mid-South),*** Administrative Agent for the City, as subcontractor for the planning and implementation of the **Craighead County Connections for Kids Project (CCCK).**

This Letter of Intent sets forth the understanding between ***Mid-South Health Systems*** and the ***Craighead County Juvenile Probation Department*** whereby, the Juvenile Department is supportive of the Craighead County Connections for Kids Project (CCCK) and will fulfill certain Award obligations on behalf of Mid-South. More specifically, they intend to:

- Refer juveniles to the program to prevent court action.
- Refer juveniles currently in the court system to the program to reduce recidivism rates.
- Assist employees of this grant in filing court action against non-compliant referrals.
- Allowing screeners the use of county facilities while assessing juveniles.

Further, it is the intent of **Mid-South** to:

- Provide prompt response to requests for assessment/emergency screenings.
- Provide clinical services to youth referred to the project.
- Work cooperatively with Juvenile Justice Staff to promote goals and objectives of the project.

We, the undersigned, have participated with Mid-South and the City of Jonesboro in the development of the application for the Award and are committed to the development of a Comprehensive Family Centered System of Care in Craighead County, Arkansas and the objectives as set forth in the application.

Craighead County Juvenile Department

Mid-South Health Systems, Inc.

Arkansas Department of Human Services
Division of Children & Family Services
Craighead County
2920 McClellan Drive
Jonesboro, AR 72401
870-972-1732
fax: 870-972-0360

October 9, 2003

LETTER OF INTENT

The City of Jonesboro, Arkansas is applying to the Substance Abuse and Mental Health Services Administration under RFA SM03-009 for a cooperative agreement for the development of a "systems of care" in Craighead County, Arkansas, that will deliver effective, comprehensive community mental health services to children and adolescents in the county who have a serious emotional disturbance and their families. In anticipation of this award, the City has designated Mid-South Health Systems, Inc., Administrative Agent for the City, as subcontractor for the planning and implementation of the Craighead County Connections for Kids Project (CCCK).

This Letter of Intent sets forth the understanding between Mid-South Health Systems and the Craighead County Division of Children & Family Services (DCFS) whereby, DCFS is supportive of the Craighead County Connections for Kids Project (CCCK) and will fulfill certain Award obligations on behalf of Mid-South. More specifically, they intend to:

1.) Provide a representative for participation on the community advisory board.
2.) Cooperate with program evaluations as the grant progresses.
3.) Participate in planning activities, training, etc.

Further, it is the intent of Mid-South to:

1.) Provide adequate staff to address the goals/objectives of the grant.
2.) Cooperate with program evaluations.
3.) Direct planning activities, training, etc.

We, the undersigned, have participated with Mid-South and the City of Jonesboro in the development of the application for the Award and are committed to the development of a Comprehensive Family Centered System of Care in Craighead County, Arkansas and the objectives set forth in the application.

Craighead County Division of Children & Family Services

Mid-South Health Systems, Inc.

LETTER OF INTENT

The **City of Jonesboro, Arkansas (City)** is applying to the *Substance Abuse and Mental Health Services Administration* under RFA SM03-009 for a cooperative agreement for the development of a "systems of care" in Craighead County, Arkansas, that will deliver effective, comprehensive community mental health services to children and adolescents in the county who have a serious emotional disturbance and their families. In anticipation of this award, the City has designated ***Mid-South Health Systems, Inc. (Mid-South),*** Administrative Agent for the City, as subcontractor for the planning and implementation of the **Craighead County Connections for Kids Project (CCCK).**

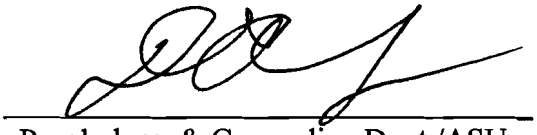
This Letter of Intent sets forth the understanding between ***Mid-South Health Systems*** and the ***Psychology & Counseling Department/ASU*** whereby, the Psychology & Counseling Department is supportive of the Craighead County Connections for Kids Project (CCCK) and will fulfill certain Award obligations on behalf of Mid-South. More specifically, they intend to:

- Provide evaluation services (e.g., data collation, data analysis, reports)
- Serve as liaison with national evaluators
- Provide consultation for evaluation elements of grant

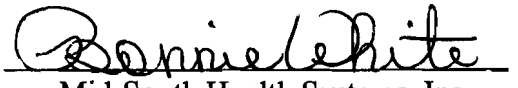
Further, it is the intent of **Mid-South** to:

- To utilize the evaluation services of the ASU Psychology/Counseling Dept.
- Fully participate and cooperate in data collection for the national evaluation

We, the undersigned, have participated with Mid-South and the City of Jonesboro in the development of the application for the Award and are committed to the development of a Comprehensive Family Centered System of Care in Craighead County, Arkansas and the objectives as set forth in the application.



Psychology & Counseling Dept./ASU



Mid-South Health Systems, Inc.

LETTER OF INTENT

The **City of Jonesboro, Arkansas (City)** is applying to the *Substance Abuse and Mental Health Services Administration* under RFA SM03-009 for a cooperative agreement for the development of a "systems of care" in Craighead County, Arkansas, that will deliver effective, comprehensive community mental health services to children and adolescents in the county who have a serious emotional disturbance and their families. In anticipation of this award, the City has designated ***Mid-South Health Systems, Inc. (Mid-South),*** Administrative Agent for the City, as subcontractor for the planning and implementation of the **Craighead County Connections for Kids Project (CCCK).**

This Letter of Intent sets forth the understanding between ***Mid-South Health Systems*** and the ***ASU-Department of Social Work*** whereby, the Department of Social Work is supportive of the Craighead County Connections for Kids Project (CCCK) and will fulfill certain Award obligations on behalf of Mid-South. More specifically, they intend to:

- Incorporate a unit of study specific to drug use and abuse with children and adolescents
- Develop a course in case management specific to a systems of care approach for children with serious emotional disturbances and those with co-occurring disturbances
- Develop a course addressing cultural diversity which addresses minority issues within the system of care
- Provide qualitative evaluation methods for implementation and summary evaluations. These methods would address questions pertaining to barriers and facilitators affecting coordination of services and other aspects of the implementation plan

Further, it is the intent of **Mid-South** to:

- Work closely with the Social Work Department to develop key elements of curriculum which will best training needs of staff working with the system of care program
- Assess and recommend other additional curriculum which will further enhance the training needs of staff with the system of care program
- Utilize information gained from the qualitative evaluation to remove barriers to coordination of services and improve and strengthen interagency coordination of services

We, the undersigned, have participated with Mid-South and the City of Jonesboro in the development of the application for the Award and are committed to the development of a Comprehensive Family Centered System of Care in Craighead County, Arkansas and the objectives as set forth in the application.

Department of Social Work/ASU

Mid-South Health Systems, Inc.

Alice Baugh

LETTER OF INTENT

The **City of Jonesboro, Arkansas (City)** is applying to the *Substance Abuse and Mental Health Services Administration* under RFA SM03-009 for a cooperative agreement for the development of a "systems of care" in Craighead County, Arkansas, that will deliver effective, comprehensive community mental health services to children and adolescents in the county who have a serious emotional disturbance and their families. In anticipation of this award, the City has designated ***Mid-South Health Systems, Inc. (Mid-South),*** Administrative Agent for the City, as subcontractor for the planning and implementation of the **Craighead County Connections for Kids Project (CCCK).**

This Letter of Intent sets forth the understanding between ***Mid-South Health Systems*** and the ***St. Bernard's Behavioral Health (SBH)*** whereby, St. Bernard Behavioral Health is supportive of the Craighead County Connections for Kids Project (CCCK) and will fulfill certain Award obligations on behalf of Mid-South. More specifically, they intend to:

- Involve and collaborate with care teams concerning services and treatment provided by their agency to children and adolescents in the Craighead County Connections for Kids Project, and
- Will collaborate with care teams in the discharge planning process for children and adolescents in the CCCK Project.

Further, it is the intent of **Mid-South** to:

- Coordinate the collaborative efforts between care teams and St. Bernard's Behavioral Health in the treatment and discharge process of children and adolescents participating in the Craighead County Connections for Kids Project.

We, the undersigned, have participated with Mid-South and the City of Jonesboro in the development of the application for the Award and are committed to the development of a Comprehensive Family Centered System of Care in Craighead County, Arkansas and the objectives as set forth in the application.

Lee Simpson MD
St. Bernard's Behavioral Health

Bonnie White
Mid-South Health Systems, Inc.

MEMORANDUM OF SUPPORT

As Circuit Judges serving the Juvenile System in Craighead County, we are supportive of the City of Jonesboro's application to the Substance Abuse and Mental Health Services Administration (SAMHSA) for a cooperative agreement for the development of a "system of care" in Craighead County, Arkansas, that will deliver effective, comprehensive community mental health services to children and adolescents in the county who have a serious emotional disturbance (SED) and their families.

We realize that children with SED come from wealthy, middle class, and poor families from every race and culture and that many of these children are not receiving needed mental health services, or the services they are receiving are fragmented. As a result, many of these children end up in trouble at school, in the community and eventually end up in our juvenile court system.

Through the Craighead County Connections for Kids Project, we hope to see (a) these SED children identified, (b) an array of services provided that will allow these children to remain in their homes and schools, (c) that services and support for their families is provided, and (d) that services across agencies and organizations is integrated so that gaps and fragmentation of services can be eliminated.

We recognize that the successful development of a system of care in this county must involve all related agencies and organizations in the community, therefore, we are proud to support and participate in this initiative and will support the evaluation component and annual reporting requirements of this initiative.

October 8, 2003

Judge David Goodson (Date)
Second Judicial Circuit

10-8-2003

Judge Lee Fergus (Date)
Second Judicial Circuit

10-8-03

Judge Ralph Wilson, Jr. (Date)
Second Judicial Circuit

Arkansas Department of Human Services
Division of Mental Health Services

4313 West Markham
Little Rock, Arkansas 72205-4096
Telephone (501) 686-9000 FAX (501) 686-9182 TDD (501) 686-9176

October 7, 2003

Mayor Hubert Brodell
515 West Washington
Jonesboro, AR 72401

Dear Mayor Brodell:

As Director of the Division of Behavioral Health Services in Arkansas (the Division), I would like to express this agency's support of the City of Jonesboro's application to the Substance Abuse and Mental Health Services Administration (SAMHSA) for funding to develop a system of care in Craighead County that will deliver effective, comprehensive community mental health services to children and adolescents with serious emotional disturbances (SED) and their families.

This grant will provide a unique opportunity for this community to enhance services to improve the quality of life for children with serious emotional disturbances and their families and, hopefully, will launch a statewide transformation in the provision of mental health services for these children.

The Division of Behavioral Health Services supports the system of care described in the Craighead County Connections for Kids Project and will encourage its inclusion in a revision of the Arkansas Community Mental Health Services Block Grant Plan as authorized in Section 564 (b) of the PHS Act and the Mental Health Plan for Children and Adolescents with Serious Emotional Disturbances submitted under Public Law (PL) 102-321. Our goal will be to see that these changes are made by the next plan renewal date.

The Division is also supportive of Mid-South Health Systems efforts to provide for the direct delivery of any required services under this cooperative agreement. Mid-South is a certified community mental health center in Arkansas serving seven (7) counties in Northeast Arkansas, including Craighead County, and is a designated provider for Rehabilitative Services for Persons with Mental Illness (RSPMI). Mid-South is compliant with the State Medicaid Plan, and is, thereby, qualified to receive Medicaid payments.

Please be assured that changes in funding streams required for the non-federal match and other funding innovations necessary for implementation of the proposed project will be supported by this office as assured by the Governor's letter. We also pledge our commitment to help the city identify ways to sustain this project after project funding ends and will fully support the evaluation component of this initiative and its annual reporting requirements.

Sincerely,

Pat Dahlgren
Director

PD:sm

COLLEGE OF NURSING AND HEALTH PROFESSIONS

Alice Baugh

ARKANSAS STATE UNIVERSITY

P.O. Box 910
State University, AR 72467-0910

Phone:
870-972-3112

Fax:
870-972-2040

www.astate.edu

Jonesboro, Arkansas

October 8, 2003

Bonnie White, CEO
Mid-South Health Systems
2707 Browns Lane
Jonesboro, AR 72401

Dear Bonnie:

This is a letter of support for the Craighead County Mental Health Initiative proposal to be funded through DHHS, Substance Abuse and Mental Health Services, Center for Mental Health Services (RFA SM-03-009). Your proposal to develop a system of care that delivers comprehensive community mental health services to children (which includes family involvement) who have severe emotional disturbances is welcomed and long overdue. I am not aware of a DHHS grant of this nature since my arrival in 1995.

The College of Nursing and Health Professions at Arkansas State University is a ready and willing partner for the planning and implementation of this grant. We have a very strong accredited Bachelor's in Social Work (BSW) program with a Master's in Social Work degree pending approval at the university. We are the oldest BSW program in the state and graduate approximately 50 students per year from that program. We have a broad array of "for credit" courses and have the capacity to provide training or develop other modules necessary for educational purposes at whatever level of support might be necessary. We also have a very large nursing program (500 students in associate, baccalaureate and master's degree programs) which would enhance our capacity to provide mental health deliverables.

Faculty in social work are skilled in program evaluation and feedback. We have been a contractor for those services in previous grants and would be excited to provide planning, implementation and data analysis support with this piece of your initiative. Process and outcome evaluation will be part of that system of comprehensive evaluation.

The Craighead County community continues to have "needs" relative to behavioral health service delivery especially in the youth and adolescent population. "Gaps in care" are apparent to those who work with these children on a regular basis. The provisions of this grant and the partners you have included will adequately fill those voids. All of us want healthier children to be part of healthier families which only makes our community stronger. We will be happy to do whatever we can to support you in this effort.

Sincerely,

Susan Hanrahan, Dean
College of Nursing and Health Professions

Consolidated Youth Services, Inc.

4220 Stadium Blvd.•Jonesboro, Arkansas 72404•Phone (501) 972-1110•FAX (501) 972-5433

TO: Mayor Hubert Brodell

DATE: October 13, 2003

SUBJECT: Letter of Support for SAMHSA Grant Application

As Director of Consolidated Youth Services, an agency working with troubled youth in our community, I would like to express this organization's support of the City of Jonesboro in its efforts to develop a system of care in Craighead County that will deliver effective, comprehensive community mental health services to children and adolescents with serious emotional disturbances (SED) and their families.

We realize those children with SED come from wealthy, middle class and poor families from every race and culture and that many of these children are not receiving needed mental health services, or the services they are receiving are fragmented. This grant will provide a unique opportunity for this community to pull these services together and to fill gaps in services so that these children and their families will have an improved quality of life.

Consolidated Youth Services is also supportive of Mid-South Health Systems' efforts to provide for the direct delivery of services under this cooperative agreement. We have worked with Mid-South Health Systems for many years and are confident of their ability as a community mental health center to provide the required services.

We also recognize that the success of a system of care involves all related agencies and organizations in the community working together, therefore, Consolidated Youth Services is proud to support and participate in this initiative. We will fully support and cooperate in the evaluation component of this project and pledge our commitment to helping identify ways to sustain this project after project funding has ended.

Sincerely,

Bonnie Smith
Executive Director
CYS, Inc.

BS/bh

LETTER OF SUPPORT

TO: Mayor Hubert Brodell

DATE: October 13, 2003

SUBJECT: Letter of Support for SAMHSA Grant Application

City Youth Ministries would like to express its support of the City of Jonesboro's efforts in developing a system of care in Craighead County. Such a system will be more effective in delivering comprehensive community mental health services to children and adolescents with serious emotional disturbances (SED) and their families.

Working with children, we realize that children with SED come not only from poor families, but from wealthy and middle class families and from every race and culture. Many of these children are not receiving needed mental health services, or the services they are receiving are fragmented. This grant will provide a unique opportunity for this community to pull these services together and to fill gaps in services so that these children and their families will have an improved quality of life.

City Youth Ministries is also supportive of Mid-South Health Systems' efforts to provide for the direct delivery of services under this cooperative agreement. As a community mental health center located in Craighead County, they are very familiar with the needs of these children and have strived to serve these children and their families for many years.

The success of such a system of care involves all related agencies and organizations in the community working together, therefore, we are proud to support and participate in this initiative. We will fully support and cooperate in the evaluation component of this project and pledge our commitment to helping identify ways to sustain this project after project funding has ended.

Sincerely,

Bonnie May

Bonnie May, Director
City Youth Ministries

Governor's Assurance

As Governor of the State of Arkansas, it is my pleasure to designate the City of Jonesboro, Arkansas, as the intended applicant for the Substance Abuse and Mental Health Services Administration Center for Mental Health Services RFA SM-03-009: Cooperative Agreements for the Comprehensive Community Mental Health Services Program for Children and Their Families. As Mayor of the City of Jonesboro, Hubert Brodell will be the individual responsible for signing and submitting the application.

The system of care described in Craighead County Connections for Kids Project will be included in a revision of the Arkansas Community Mental Health Services Block Grant Plan as authorized in Section 564 (b) of the PHS Act and the Mental Health Plan for Children and Adolescents with Serious Emotional Disturbances submitted under Public Law (PL) 102-321. These changes will be made by next plan renewal dates. Furthermore, the applicant has entered into an agreement with Mid-South Health Systems, Inc. who will provide directly any service required in this cooperative agreement which is covered in our State's Medicaid Plan. Likewise, Mid-South Health Systems is a designated provider for Rehabilitative Services for Persons with Mental Illness (RSPMI) and is compliant with the State Medicaid Plan, and is thereby qualified to receive Medicaid payments.

Please be assured that changes in funding streams required for the non-federal match and other funding innovations necessary for implementation of the proposed project will be allowed and actively supported by my office and that of the Mayor.

Mike Huckabee
Governor, State of Arkansas

10-9-03
Date

The following measures are intended to be used to evaluate the effectiveness of the Craighead County Connections for Kids Project:

- **CBCL (Child Behavior Checklist)**

A device which parents and other individuals who know the child well rate a child's problem behaviors and competencies. It can also be used to measure a child's change in behavior over time or following treatment. (Achenbach)

- **YSR (Youth Self-Report)**

Provides self-ratings for 20 competence and problem items paralleling those of the CBCL/Ages 6-18. The YSR also includes open-ended responses to items covering physical problems, concerns, and strengths. Youths rate themselves for how true each item is now or was within the past six months. (vinst.umdnj.edu/VAID/TestReport.asp?Code=YSR)

- **CAFAS (Child and Adolescent Functional Assessment Scale)**

CAFAS is an inventory for measuring functional impairment in children and adolescents due to emotional, behavioral, psychological, psychiatric, or substance abuse problems.)

Other measures will be used in the evaluation of CCCK. The decisions as to which additional instruments will be used will be made during the first (planning) year of the grant. The following instruments will be looked at as well as many others to determine which ones will best fit our needs.

- **CALOCUS (Child and Adolescent levels of Care Utilization System)**

CALOCUS is a dimensional rating system used to determine the intensity of a child's or adolescent's service needs by operationalizing many factors clinicians consider in determining the most appropriate services and level of care needed .

- **FSS (Family Support Scale)**

Assesses the degree to which potential sources of social support have been helpful to families. (Early, 2001)

- **FRS (Family Resource Scale)**

Measures tangible and intangible resources that are considered important for families with young children. Can be used to identify areas in which the family is successfully meeting needs and for identifying goals. (Early, 2001)

- **BERS (Behavioral and Emotional Rating)**

Assesses children's emotional and behavioral strengths. The primary uses are to identify and document the emotional and behavioral strengths of children, to identify individuals with limited strengths, to target goals for individualized educational programs and treatment plans, to measure progress in a strength area as an outcome of specialized services and to assess strengths in research area as an outcome of specialized services and to assess strengths in research and evaluation projects.

- **School Success Profile (SSP)**

Measures protective and risk factors in the areas of neighborhood, school, friends, and family. (Early, 2001)

- **SSRS (Social Skills Rating System)**

This rating system allows professionals to screen and classify children and adolescents suspected of having significant social behavior problems .

Due to the length of some documents, not all could be enclosed in their entirety, but we are enclosing excerpts from each.

Alice Baugh

Please print. Be sure to answer all items.

CHILD BEHAVIOR CHECKLIST FOR AGES 1½-5

For office use only
ID #

CHILD'S FULL NAME: First Middle Last

CHILD'S GENDER: ☐ Boy ☐ Girl

CHILD'S AGE

CHILD'S ETHNIC GROUP OR RACE

TODAY'S DATE: Mo. ____ Day ____ Year ____

CHILD'S BIRTHDATE: Mo. ____ Day ____ Year ____

Please fill out this form to reflect *your* view of the child's behavior even if other people might not agree. Feel free to write additional comments beside each item and in the space provided on page 2. ***Be sure to answer all items.***

PARENTS' USUAL TYPE OF WORK, even if not working now. *Please be specific — for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.*

FATHER'S TYPE OF WORK _____

MOTHER'S TYPE OF WORK _____

THIS FORM FILLED OUT BY: (print your full name)

_____

Your relationship to child:

☐ Mother ☐ Father ☐ Other (specify):

Below is a list of items that describe children. For each item that describes the child ***now or within the past 2 months***, please circle the ***2*** if the item is ***very true or often true*** of the child. Circle the ***1*** if the item is ***somewhat or sometimes true*** of the child. If the item is ***not true*** of the child, circle the ***0***. Please answer all items as well as you can, even if some do not seem to apply to the child.

0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Often True

0 1 2 1. Aches or pains (without medical cause; *do not* include stomach or headaches)
0 1 2 2. Acts too young for age
0 1 2 3. Afraid to try new things
0 1 2 4. Avoids looking others in the eye
0 1 2 5. Can't concentrate, can't pay attention for long
0 1 2 6. Can't sit still, restless, or hyperactive
0 1 2 7. Can't stand having things out of place
0 1 2 8. Can't stand waiting; wants everything now
0 1 2 9. Chews on things that aren't edible
0 1 2 10. Clings to adults or too dependent
0 1 2 11. Constantly seeks help
0 1 2 12. Constipated, doesn't move bowels (when not sick)
0 1 2 13. Cries a lot
0 1 2 14. Cruel to animals
0 1 2 15. Defiant
0 1 2 16. Demands must be met immediately
0 1 2 17. Destroys his/her own things
0 1 2 18. Destroys things belonging to his/her family or other children
0 1 2 19. Diarrhea or loose bowels (when not sick)
0 1 2 20. Disobedient
0 1 2 21. Disturbed by any change in routine
0 1 2 22. Doesn't want to sleep alone
0 1 2 23. Doesn't answer when people talk to him/her
0 1 2 24. Doesn't eat well (describe): _____
0 1 2 25. Doesn't get along with other children
0 1 2 26. Doesn't know how to have fun; acts like a little adult
0 1 2 27. Doesn't seem to feel guilty after misbehaving
0 1 2 28. Doesn't want to go out of home
0 1 2 29. Easily frustrated
0 1 2 30. Easily jealous
0 1 2 31. Eats or drinks things that are not food—*don't* include sweets (describe): _____
0 1 2 32. Fears certain animals, situations, or places (describe): _____
0 1 2 33. Feelings are easily hurt
0 1 2 34. Gets hurt a lot, accident-prone
0 1 2 35. Gets in many fights
0 1 2 36. Gets into everything
0 1 2 37. Gets too upset when separated from parents
0 1 2 38. Has trouble getting to sleep
0 1 2 39. Headaches (without medical cause)
0 1 2 40. Hits others
0 1 2 41. Holds his/her breath
0 1 2 42. Hurts animals or people without meaning to
0 1 2 43. Looks unhappy without good reason
0 1 2 44. Angry moods
0 1 2 45. Nausea, feels sick (without medical cause)
0 1 2 46. Nervous movements or twitching (describe): _____
0 1 2 47. Nervous, highstrung, or tense
0 1 2 48. Nightmares
0 1 2 49. Overeating
0 1 2 50. Overtired
0 1 2 51. Shows panic for no good reason
0 1 2 52. Painful bowel movements (without medical cause)
0 1 2 53. Physically attacks people
0 1 2 54. Picks nose, skin, or other parts of body (describe): _____

Be sure you answered all items. Then see other side.

7-28-00 Edition

Please print your answers. Be sure to answer all items.

0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Often True

0 1 2 55. Plays with own sex parts too much
0 1 2 56. Poorly coordinated or clumsy
0 1 2 57. Problems with eyes (without medical cause) (describe): _____
0 1 2 58. Punishment doesn't change his/her behavior
0 1 2 59. Quickly shifts from one activity to another
0 1 2 60. Rashes or other skin problems (without medical cause)
0 1 2 61. Refuses to eat
0 1 2 62. Refuses to play active games
0 1 2 63. Repeatedly rocks head or body
0 1 2 64. Resists going to bed at night
0 1 2 65. Resists toilet training (describe): _____
0 1 2 66. Screams a lot
0 1 2 67. Seems unresponsive to affection
0 1 2 68. Self-conscious or easily embarrassed
0 1 2 69. Selfish or won't share
0 1 2 70. Shows little affection toward people
0 1 2 71. Shows little interest in things around him/her
0 1 2 72. Shows too little fear of getting hurt
0 1 2 73. Too shy or timid
0 1 2 74. Sleeps less than most kids during day and/or night (describe): _____
0 1 2 75. Smears or plays with bowel movements
0 1 2 76. Speech problem (describe): _____
0 1 2 77. Stares into space or seems preoccupied
0 1 2 78. Stomachaches or cramps (without medical cause)
0 1 2 79. Rapid shifts between sadness and excitement
0 1 2 80. Strange behavior (describe): _____
0 1 2 81. Stubborn, sullen, or irritable
0 1 2 82. Sudden changes in mood or feelings
0 1 2 83. Sulks a lot
0 1 2 84. Talks or cries out in sleep
0 1 2 85. Temper tantrums or hot temper
0 1 2 86. Too concerned with neatness or cleanliness
0 1 2 87. Too fearful or anxious
0 1 2 88. Uncooperative
0 1 2 89. Underactive, slow moving, or lacks energy
0 1 2 90. Unhappy, sad, or depressed
0 1 2 91. Unusually loud
0 1 2 92. Upset by new people or situations (describe): _____
0 1 2 93. Vomiting, throwing up (without medical cause)
0 1 2 94. Wakes up often at night
0 1 2 95. Wanders away
0 1 2 96. Wants a lot of attention
0 1 2 97. Whining
0 1 2 98. Withdrawn, doesn't get involved with others
0 1 2 99. Worries
0 1 2 100. Please write in any problems the child has that were not listed above.
0 1 2 _____
0 1 2 _____
0 1 2 _____

Please be sure you have answered all items. Underline any you are concerned about.

Does the child have any illness or disability (either physical or mental)? ☐ No ☐ Yes—Please describe:

What concerns you most about the child?

Please describe the best things about the child:

Please print

CHILD BEHAVIOR CHECKLIST FOR AGES 6-18

For office use only ID #:

CHILD'S FULL NAME First Middle Last

CHILD'S GENDER ☐ Boy ☐ Girl

CHILD'S AGE

CHILD'S ETHNIC GROUP OR RACE

TODAY'S DATE Mo. ____ Day ____ Year ____

CHILD'S BIRTHDATE Mo. ____ Day ____ Year ____

GRADE IN SCHOOL ____

NOT ATTENDING SCHOOL ☐

Please fill out this form to reflect *your* view of the child's behavior even if other people might not agree. Feel free to print additional comments beside each item and in the space provided on page 2. ***Be sure to answer all items.***

PARENTS' USUAL TYPE OF WORK, even if not working now.
(Please be specific — for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.)

FATHER'S TYPE OF WORK ____

MOTHER'S TYPE OF WORK ____

THIS FORM FILLED OUT BY: (print your full name) ____

Your gender: ☐ Male ☐ Female

Your relation to the child:

☐ Biological Parent ☐ Step Parent ☐ Grandparent
☐ Adoptive Parent ☐ Foster Parent ☐ Other (specify)

I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

None ☐

a. ____
b. ____
c. ____

Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average	Don't Know
☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐	☐	☐

II. Please list your child's favorite hobbies, activities, and games other than sports. For example: stamps, dolls, piano, crafts, cars, computer, singing, etc. (Do *not* include listening to radio or TV.)

None ☐

a. ____
b. ____
c. ____

Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average	Don't Know
☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐	☐	☐

III. Please list any organizations, clubs, teams, or groups your child belongs to.

None ☐

a. ____
b. ____
c. ____

Compared to others of the same age, how active is he/she in each?			
Less Active	Average	More Active	Don't Know
☐	☐	☐	☐
☐	☐	☐	☐
☐	☐	☐	☐

IV. Please list any jobs or chores your child has. For example: paper route, babysitting, making bed, working in store, etc. (Include both paid and unpaid jobs and chores.)

None ☐

a. ____
b. ____
c. ____

Compared to others of the same age, how well does he/she carry them out?			
Below Average	Average	Above Average	Don't Know
☐	☐	☐	☐
☐	☐	☐	☐
☐	☐	☐	☐

Be sure you answered all items. Then see other side.

Please print. Be sure to answer all items.

V. 1. About how many close friends does your child have? (Do *not* include brothers & sisters)

☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more

2. About how many times a week does your child do things with any friends outside of regular school hours? (Do *not* include brothers & sisters) ☐ Less than 1 ☐ 1 or 2 ☐ 3 or more

VI. Compared to others of his/her age, how well does your child:

	Worse	Average	Better	
a. Get along with his/her brothers & sisters?	☐	☐	☐	☐ Has no brothers or sisters
b. Get along with other kids?	☐	☐	☐	
c. Behave with his/her parents?	☐	☐	☐	
d. Play and work alone?	☐	☐	☐	

VII. 1. Performance in academic subjects. Does not attend school because _____

Check a box for each subject that child takes

	Falling	Below Average	Average	Above Average
a. Reading, English, or Language Arts	☐	☐	☐	☐
b. History or Social Studies	☐	☐	☐	☐
c. [illegible] Math	☐	☐	☐	☐
d. Science	☐	☐	☐	☐
e. _____	☐	☐	☐	☐
f. _____	☐	☐	☐	☐
g. _____	☐	☐	☐	☐

Other academic subjects–for example: computer courses, foreign language, business. Do *not* include gym, shop, driver's ed., or other nonacademic subjects.

2. Does your child receive special education or remedial services or attend a special class or special school?

☐ No ☐ Yes—kind of services, class, or school:

3. Has your child repeated any grades? ☐ No ☐ Yes—grades and reasons:

4. Has your child had any academic or other problems in school? ☐ No ☐ Yes—please describe:

When did these problems start? _____

Have these problems ended? ☐ No ☐ Yes–when?

Does your child have any illness or disability (either physical or mental)? ☐ No ☐ Yes—please describe:

What concerns you most about your child?

Please describe the best things about your child.

Be sure you answered all items.

Alice Baugh

Please print

YOUTH SELF-REPORT FOR AGES 11-18

For office use only
ID #

YOUR FULL NAME: First Middle Last

YOUR GENDER ☐ Boy ☐ Girl

YOUR AGE

YOUR ETHNIC GROUP OR RACE

TODAY'S DATE Mo. ____ Day ____ Year ____

YOUR BIRTHDATE Mo. ____ Day ____ Year ____

GRADE IN SCHOOL ____

NOT ATTENDING SCHOOL ☐

IF YOU ARE WORKING, PLEASE STATE YOUR TYPE OF WORK:

PARENTS' USUAL TYPE OF WORK, even if not working now.
(Please be specific — for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.)

FATHER'S TYPE OF WORK ____

MOTHER'S TYPE OF WORK ____

Please fill out this form to reflect *your* views, even if other people might not agree. Feel free to print additional comments beside each item and in the spaces provided on pages 2 and 4. ***Be sure to answer all items.***

I. Please list the sports you most like to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

None ☐

a. ____
b. ____
c. ____

Compared to others of your age, about how much time do you spend in each?

Less Than Average	Average	More Than Average
☐	☐	☐
☐	☐	☐
☐	☐	☐

Compared to others of your age, how well do you do each one?

Below Average	Average	Above Average
☐	☐	☐
☐	☐	☐
☐	☐	☐

II. Please list your favorite school subjects, activities, and games, other than sports. For example: cards, books, piano, crafts, cars, computers, etc. (Do *not* include listening to radio or TV.)

None ☐

a. ____
b. ____
c. ____

Compared to others of your age, about how much time do you spend in each?

Less Than Average	Average	More Than Average
☐	☐	☐
☐	☐	☐
☐	☐	☐

Compared to others of your age, how well do you do each one?

Below Average	Average	Above Average
☐	☐	☐
☐	☐	☐
☐	☐	☐

III. Please list any organizations, clubs, teams, or groups you belong to.

None ☐

a. ____
b. ____
c. ____

Compared to others of your age, how active are you in each?

Less Active	Average	More Active
☐	☐	☐
☐	☐	☐
☐	☐	☐

IV. Please list any jobs or chores you have. For example: paper route, babysitting, making bed, working in store, etc. (Include *both* paid and unpaid jobs and chores.)

None ☐

a. ____
b. ____
c. ____

Compared to others of your age, how well do you carry them out?

Below Average	Average	Above Average
☐	☐	☐
☐	☐	☐
☐	☐	☐

Be sure you answered all items. Then see other side.

Please print. Be sure to answer all items.

V. 1. About how many close friends do you have? (Do *not* include brothers & sisters)

☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more

2. About how many times a week do you do things with your friends outside of regular school hours? (Do *not* include brothers & sisters)

☐ Less than 1 ☐ 1 or 2 ☐ 3 or more

VI. Compared to others of your age, how well do you:

	Worse	Average	Better	
a. Get along with your brothers & sisters?	☐	☐	☐	☐ I have no brothers or sisters
b. Get along with other kids?	☐	☐	☐	
c. Behave with your parents?	☐	☐	☐	
d. Do things by yourself?	☐	☐	☐	

VII.1.Performance in academic subjects. ☐ I do not attend school because _____

Check one box for each subject that you take.

	Failing	Below Average	Average	Above Average
a. Reading, English, or Language Arts	☐	☐	☐	☐
b. History or Social Studies	☐	☐	☐	☐
c. Algebra or Math	☐	☐	☐	☐
d. Science	☐	☐	☐	☐
e. _____	☐	☐	☐	☐
f. _____	☐	☐	☐	☐
g. _____	☐	☐	☐	☐

Other academic subjects–for example: computer courses, foreign language, business. Do *not* include gym, shop, driver's ed., or other nonacademic subjects.

Do you have any illness, disability, or handicap? ☐ No ☐ Yes—please describe:

Please describe any concerns or problems you have about school:

Please describe any other concerns you have:

Please describe the best things about yourself:

CHILD AND ADOLESCENT FUNCTIONAL ASSESSMENT SCALE (CAFAS®)

Name _____ Child ID # _____ Sex: ☐ boy ☐ girl

Today's Date ____/____/____ Admission Date ____/____/____ *(optional)* Date of Birth ____/____/____ Age _____

Agency/Site ID # ___/___/___/___/___/___/___/___/___ Rater ID# ___/___/___/___/___/___/___/___/___

TIME PERIOD RATED FOR CAFAS:
☐ Last Month ☐ Last 3 Months ☐ Other_____ Rater Signature _____

YOUTH'S PLACEMENT:
☐ Family/Relative Home ☐ Foster Home ☐ Therapeutic Foster ☐ Detention/Jail ☐ Other Residential

CAFAS ADMINISTRATION:
☐ 1st Evaluation ☐ 2nd Evaluation ☐ 3 Months ☐ 6 Months ☐ 9 Months
☐ 12 Months ☐ 15 Months ☐ 18 Months ☐ 21 Months ☐ 24 Months
☐ Exit from Service ☐ Change in Intensity of Service ☐ Unknown ☐ Other_____

INSTRUCTIONS: *Only persons who have established that they are reliable raters should rate the CAFAS®.* Reliability is established by using the CAFAS® Self-Training Manual. Be sure to rate the youth's most SEVERE level of dysfunction for the time period being rated. The CAFAS is designed as a measure of functional status and should not be used as the sole criterion for determining any clinical decision, including need or eligibility for services, intensity of services, or dangerousness to self or others. Note that a list of strengths/goals follows each scale. Each characteristic can be viewed as a strength (i.e., youth has the characteristic currently) or a goal (i.e., youth does not yet have the characteristic but it is a goal in the youth's individualized service plan). You may circle as many strengths and goals as you like to assist in developing a treatment plan (see last two pages). These items are separate from the CAFAS and do not affect the scoring of the CAFAS. The rater should sign this form (see above).

CAFAS SCORING SUMMARY

SCALE SCORES FOR YOUTH'S FUNCTIONING

5 Scales		8 Scales
_____	ROLE PERFORMANCE (highest)	
	SCHOOL/WORK	_____
	HOME	_____
	COMMUNITY	_____
_____	BEHAVIOR TOWARD OTHERS	_____
_____	MOODS/SELF-HARM (higher)	
	MOODS/EMOTIONS	_____
	SELF-HARMFUL BEHAVIOR	_____
_____	SUBSTANCE USE	_____
_____	THINKING	_____
_____	TOTAL FOR YOUTH based on 5 Scales	
	TOTAL FOR YOUTH based on 8 Scales	_____

SCALE SCORES FOR CAREGIVER'S RESOURCES

Primary_____ Other_____

MATERIAL NEEDS	_____	_____
FAMILY/SOCIAL SUPPORT	_____	_____

RISK BEHAVIORS:

Youth's Functioning

- ☐ Has made a serious suicide attempt or is considered to be actively suicidal (119, 142-145) or possibly suicidal (146-148)
- ☐ Has been or may be harmful to others or self due to:
  - ☐ Aggression:
    - ☐ at School (3,4) ☐ in the Community (68)
    - ☐ at Home (43) ☐ in Behavior in general (89)
  - ☐ Sexual Behavior (69, 77, 90)
  - ☐ Fire Setting (71, 78)
- ☐ Runaway Behavior (48, 54)
- ☐ Psychotic or Organic symptoms in the context of severe impairment (182-186)
- ☐ Severe Substance Use (154-164)

Caregiver Resourcefulness

- ☐ Youth's needs far exceed caregiver's resources (211-221 or 289-299)

Explanation:_____

_____

_____

LEVELS OF OVERALL DYSFUNCTION BASED ON YOUTH'S TOTAL SCORE

8 Scale Sum	*5 Scale Sum*	*Description*
0-10	0-10	Youth exhibits no noteworthy impairment
20-40	20-30	Youth likely can be treated on an outpatient basis, provided that risk behaviors are not present
50-90	40-60	Youth may need additional services beyond outpatient care
100-130	70-80	Youth likely needs care which is more intensive than outpatient and/or which includes multiple sources of supportive care
140 & higher	90 & higher	Youth likely needs intensive treatment, the form of which would be shaped by the presence of risk factors and the resources available within the family and the community

CAFAS PROFILE: YOUTH'S FUNCTIONING

Level of Impairment	School/Work Role Peformance	Home Role Performance	Community Role Performance	Behavior Toward Others	Moods/ Emotions	Self-Harmful Behavior	Substance Use	Thinking
MODERATE 20	12 ○ 13 14 15 16 17 18 19 20 21	51 ○ 52 53 54 55 56	73 ○ 74 75 76 77 78 79	93 ○ 94 95 96 97 98 99 100 101 102	121 ○ 122 123 124 125 126 127	146 ○ 147 148	165 ○ 166 167 168 169 170 171	187 ○ 188 189 190 191 192
MINIMAL/NO 0	28 ○ 29 30 31 32 33 34 35 36 37 38 39	62 ○ 63 64	84 ○ 85 86	111 ○ 112 113 114	136 ○ 137 138 139 140	151 ○ 152	176 ○ 177 178 179 180	198 ○ 199

For each scale: (1) mark the item number(s) which correspond to those marked on the CAFAS form, (2) fill in the circle indicating severity level, (3) connect the circles.

Alice Baugh

Youth's Name _____ ID# _____

		Moderate Impairment *Major or persistent disruption* **(20)**		Minimal or No Impairment *No disruption of functioning* **(0)**
SCHOOL/WORK SUBSCALE Role Performance ☐		012 Non-compliant behavior which results in persistent or repeated disruption of group functioning or becomes known to authority figures other than classroom teacher (e.g., principal) because of severity and/or chronicity. 013 Inappropriate behavior which results in persistent or repeated disruption of group functioning or becomes known to authority figures other than classroom teacher (e.g., principal) because of severity and/or chronicity. 014 Frequently truant (i.e., approximately once every two weeks or for several consecutive days). 015 Frequent absences from school (i.e., approximately once every two weeks or for several consecutive days) due to impairing behavior and excluding truancy or physical illness. 016 At work, missed days or tardiness results in reprimand or equivalent. 017 Disruptive behavior, including poor attention or high activity level, resulting in individualized program or specialized treatment being needed or implemented. 018 Receiving a reprimand, warning, or equivalent at work. 019 Grade average is lower than "C" and is not due to lack of ability or any physical disabilities. 020 Failing at least half of courses and this is not due to lack of ability or any physical disabilities.		028 Reasonably comfortable and competent in relevant roles. 029 Minor problems satisfactorily resolved. 030 Functions satisfactorily even with distractions. 031 School grades are average or above. 032 Schoolwork is commensurate with ability and youth is mentally retarded. 033 Schoolwork is commensurate with ability and youth is learning disabled. 034 Schoolwork is commensurate with ability and youth is a slow learner. 035 Schoolwork is commensurate with ability and youth has a learning impairment due to maternal alcohol or drug use. 036 In a mostly vocational program and doing satisfactorily. 037 Graduated from high school or received GED. 038 Dropped out of school and is working at a job or is actively looking for a job.
		021 EXCEPTION		039 EXCEPTION
	Explanation:			COULD NOT SCORE: 040

Strengths(S)/Goals (G) for School/Work Subscale
(OPTIONAL: UNNECESSARY FOR CAFAS RATING)

S1	G1	Is permitted to attend school
S2	G2	Attends more days than not
S3	G3	Attends regularly
S4	G4	Likes going to school
S5	G5	Behavior at school is devoid of aggressive acts or threats
S6	G6	Sent to school disciplinarians infrequently
S7	G7	No incidents of being sent to school disciplinarians
S8	G8	Teacher in specialized classroom can manage behavior
S9	G9	Regular classroom teacher can manage behavior
S10	G10	Good behavior in classroom (not a problem)
S11	G11	Good behavior on the school bus
S12	G12	Gets along okay with teachers
S13	G13	Enjoys praise from teachers
S14	G14	Easily follows adult guidance
S15	G15	Benefits from assistance when problems arise
S16	G16	Completes schoolwork
S17	G17	School grades are average or above
S18	G18	Feels good about school work
S19	G19	Appreciates importance of learning academic skills
S20	G20	Likes to read
S21	G21	Can transition from one activity to another
S22	G22	Stays on task (appropriate to age)
S23	G23	Participates in after-school activities, clubs, or sports
S24	G24	Is enthusiastic about favorite activities
S25	G25	Graduated or received GED
S26	G26	Maintains steady employment
S27	G27	Satisfactory performance in job/vocation
S28	G28	For teenage parent, is continuing education
S29	G29	Other_____
S30	G30	Other_____

CALOCUS WORKSHEET

Rater Name_____ Date_____

Please check the applicable ratings within each dimension and record the score in the lower right hand corner. Total your score and determine the recommended level of care using either the Placement Grid or the Decision Tree.

I. Risk of Harm ☐ 1. Low Potential for Risk of Harm ☐ 2. Some Potential for Risk of Harm ☐ 3. Significant Potential for Risk of Harm ☐ 4. Serious Potential for Risk of Harm ☐ 5. Extreme Potential for Risk of Harm Score _____	IV-B. Recovery Environment - Level of Support ☐ 1. Highly Supportive Environment ☐ 2. Supportive Environment ☐ 3. Limited Support in Environment ☐ 4. Minimal Support in Environment ☐ 5. No Support in Environment Score _____
II. Functional Status ☐ 1. Minimal Impairment ☐ 2. Mild Impairment ☐ 3. Moderate Impairment ☐ 4. Serious Impairment ☐ 5. Severe Impairment Score _____	V. Resiliency and Treatment History ☐ 1. Full Response to Treatment ☐ 2. Significantly Resilient and/or Response to Treatment ☐ 3. Moderate or Equivocal Response to Treatment And Recovery Management ☐ 4. Poor Response to Treatment and Recovery Management ☐ 5. Negligible Response to Treatment Score _____
III. Co-Morbidity ☐ 1. No Co-Morbidity ☐ 2. Minor Co-Morbidity ☐ 3. Significant Co-Morbidity ☐ 4. Major Co-Morbidity ☐ 5. Severe Co-Morbidity Score _____	VI-A. Acceptance and Engagement - Child/Adolescent ☐ 1. Optimal ☐ 2. Constructive ☐ 3. Obstructive ☐ 4. Destructive ☐ 5. Inaccessible Score _____
IV-A. Recovery Environment - Level of Stress ☐ 1. Minimally Stressful Environment ☐ 2. Mildly Stressful Environment ☐ 3. Moderately Stressful Environment ☐ 4. Highly Stressful Environment ☐ 5. Extremely Stressful Environment Score _____	VI-B. Acceptance and Engagement - Parent/Primary Caretaker ☐ 1. Optimal ☐ 2. Constructive ☐ 3. Obstructive ☐ 4. Destructive ☐ 5. Inaccessible Score _____
Composite Score ☐	Level of Care Recommendation ☐

CALOCUS Instrument

www.wpic.pitt.edu/aacp/Ands/CALOCUSv15.pdf

SCORING SHEET
Child and Adolescent Level of Care Utilization System

A. Clinical Level of Care Recommendation (Assign before using CALOCUS) _____

B. Calculation of Composite CALOCUS Score _____

	Dimension	Dimension Rating (circle score)					
1.	Risk of Harm	1	2	3	**4**	**5**	_____
2.	Functional Status	1	2	3	**4***	**5**	_____
3.	Co-Morbidity	1	2	3	**4***	**5**	_____
4.	Recovery Environment						
	Environmental Stressors	1	2	3	4	5	_____
	Environmental Support	1	2	3	4	5	_____
5.	Resiliency and Treatment History	1	2	3	4	5	_____
6.	Acceptance and Engagement						
	Child/Adolescent	1	2	3	4	5	
	Parent and/or primary care taker	1	2	3	4	5	_____

(Note: please record the higher of the two scores)

*Note: **Bold** indicates independent criteria-requires automatic admission to a higher level of care regardless of combined score. A score of 4 results in placement at level 5 and a score of 5 results in placement at level six.*
** = independent criteria may be waived if sum of IV-A and IV-B scores equal 2.*

COMPOSITE CALOCUS SCORES (add right column) _____

C. CALOCUS Derived Level of Care Recommendation (Consult Grid and Decision Tree) _____

D. Actual (Disposition) Level of Care _____

Reason for Variance from CALOCUS Level of Care Recommendation

_____

_____

_____

Patient/Family Name: _____

Date of Scoring: _____ Name of Scorer: _____

Early Childhood Youth & Women's HEALTH

Family Resources and Supports Scale

Date Completed _____

Agency _____ Staff _____

Name _____ DOB _____ ID _____

When Completed [ ] Registration [ ] 9 months [ ] 18 months [ ] 24 months

Instructions Please check the answer that best describes how you would rate the adequacy of resources (such as time, money, & energy) and supports (such as people and groups) for you and your family.

Resources and Supports	Not At All Adequate 1	Seldom Adequate 2	Sometimes Adequate 3	Usually Adequate 4	Almost Always Adequate 5	Not Applicable 9
1. Food for 2 meals a day						
2. House or apartment						
3. Money to buy necessities						
4. Enough clothes for the family						
5. Heat for the house or apartment						
6. Plumbing/water						
7. Electric service						
8. Cooking facilities						
9. Telephone or access to phone						
10. Furniture for the home/apartment						
11. Money to pay monthly bills						
12. Money to put in savings						
13. Good job for myself						
14. Good job for my partner						
15. Medical care for myself						
16. Medical care for my child(ren)						
17. Substance abuse services						
18. Mental health services						
19. Dental care for children						
20. Public assistance (TANF, SSI, Medicaid, etc.)						
21. Regular access to dependable car						
22. Dependable public transportation						
23. Money for public transportation						
24. Babysitting for my child(ren)						
25. Child care/day care for child(ren)						
26. School services for child(ren)						
27. Early intervention services for child(ren)						
28. Money to buy things for child(ren)						
29. Support from child's physician						
30. Support from family						
31. Support from friends						
32. Support from church						
33. Time to get enough rest						
34. Time to be by myself						
35. Time to be with my partner						
36. Time to socialize						

Source: Family Resource Scale - H. E. Leet & C. J. Dunst; Family Support Scale - C. J. Dunst, V. Jenkins, & C. M. Trivette. (1988). *Enabling and Empowering Families: Principles and Guidelines for Practice*. Cambridge, MA: Brookline Books.

Appendix 3 Alice Baugh

Searchable Inventory of Instruments Assessing Violent Behavior and Related Constructs in Children and Adolescents

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Behavioral and Emotional Rating Scale

General Information

The Behavioral and Emotional Rating Scale (BERS) helps to measure the personal strengths of children ages 5 through 18. It measures five aspects of a child's strength: interpersonal strength, family involvement, intrapersonal strength, school functioning, and affective strength. The scale can be completed by teachers, parents, counselors, or other persons knowledgeable about the child. Information from the BERS is useful in evaluating children for prereferral services and placing children for specialized services. It can be used in schools, mental health clinics, and child welfare agencies.

Number of Versions:	1
Version:	Behavioral and Emotional Rating Scale
Author(s):	Michael Epstein and Jennifer Sharma
Date of Publication:	1998
Material(s) Needed for Test:	Instrument
Manual:	Available
Time to Administer:	10 minutes
Charge for one form or kit:	Yes

Purpose and Nature of Test

Construct(s) Measured:	Aggression
Population for which designed:	Age Range: 5 through 18 years old
Method of Administration:	Individual
Source of Information:	Parent, Teacher, Therapist
Subtests and Scores:	Interpersonal Strength, Family Involvement, Intrapersonal Strength, School Functioning, and

Affective Strength

Number of Items: 52

Type of Scale: Likert

Technical Evaluation

Norms:

Sample Size:	2,176
Population:	Not reported by author(s).
Culture/ethnicity:	Conforms to US census data, 1990.
SES Level:	Conforms to US census data, 1990.

Reliability:

Psychometric information:	Provided for Subscales.
The range of Test-Retest Value:	0.85 to 0.99
The range of Inter-rater reliability:	0.83 to 0.98
The range of Internal consistency:	0.77 to 0.99

Validity:

Criterion validity was assessed and found to be acceptable.

Practical Evaluation

Scoring Procedure:	Manual Scoring
Examiner Qualifications and Training Required:	None
Permission Required to Use Instrument:	Yes
If yes, by whom:	PRO-ED

Notes

Original Reference(s):

Reviewed in the Buros Institute, Mental Measurements Yearbook. http://www.unl.edu/buros/

Individual and Summary Group Profile Dimension Items

There are twenty-two dimensions on the SSP Individual and Summary Group Profiles. Fourteen dimensions characterize students' Social Environment Profile and eight dimensions represent students' Individual Adaptation Profile. In the tables below, all 22 dimensions are briefly defined, and the SSP items that are used to calculate students' codes on each dimension listed.

Social Environment Profile

Neighborhood Dimensions[1]

Neighborhood Support: (Page 1, Questions 3 a-l): Youth are satisfied with their neighborhood and perceive their neighbors as interested in their welfare and willing to help them if they have a problem.

Note: Profile code assessed by percentage of "Agree" responses to the 12 items.
a. Adults in my neighborhood are interested in what young people in the neighborhood are doing.
b. If I did something wrong, adults in my neighborhood who knew about it would probably tell the adults I live with.
c. In my neighborhood there are a lot of fun things for people my age to do.
d. If I had a problem, there are neighbors who could help me.
e. I feel safe in my neighborhood.
f. I am happy with the neighborhood I live in.
g. People in my neighborhood really help one another out.
h. Adults in my neighborhood encourage young people to get an education.
i. Adults in my neighborhood would say something to me if they saw me doing something that could get me in trouble.
j. Young people in my neighborhood show respect to adults.
k. Adults in my neighborhood seem to like young people.
l. Adults in my neighborhood can be trusted.

Neighborhood Youth Behavior (Page2, Questions 4 a-h): Youth live in a neighborhood where young people engage in constructive behavior and are unlikely to break the law and get in trouble with the police.

Note: Profile code assessed by percentage of "Likely" responses to items a, e, & g, and "Unlikely" responses to items b, c, d, f, & h.	
a. Make good grades in school	(% "Likely")
b. Get in trouble with the police	(% "Unlikely")
c. Use drugs	(% "Unlikely")
d. Join a gang	(% "Unlikely")
e. Graduate from high school	(% "Likely")
f. Carry a weapon such as a gun, knife, or club	(% "Unlikely")
g. Find a job or go to college after completing high school	(% "Likely")
h. Drink alcoholic beverages	(% "Unlikely")

[1] Neighborhood was defined on the SSP as the part of town in which you live.

Neighborhood Safety (Page 2, Neighborhood Questions 6 a-l): Youth live in a neighborhood with a low incidence of crime and violence.

Note: Profile code assessed by percentage of "No" responses to the 12 items.
During the past 30 days:
a. Someone you live with was robbed or mugged.
b. Someone in your neighborhood was robbed or mugged.
c. Someone broke into your home or a neighbor's home.
d. You heard gunshots.
e. You saw someone selling illegal drugs.
f. Someone tried to sell you illegal drugs.
g. Someone tried to get you to break the law.
h. A person was murdered.
i. A fight broke out between two gangs.
j. Someone threatened you with a weapon such as a gun, knife, or club.
k. You saw someone threatened with a weapon such as a gun, knife, or club.
l. Someone offered you an alcoholic beverage.

School Dimensions

School Satisfaction (Page 3, Questions 9 a-d and f-h): Youth enjoy going to their school, feel acknowledged and respected at school, and report that they are getting a good education.

Note: Profile code assessed by percentage of "True" responses to the 7 items.
a. I enjoy going to this school.
b. I am getting a good education at this school.
c. I like the classes that I am taking.
d. Student needs come first at this school. [2]
f. Every student is important at this school.
g. Teachers at this school seem to like young people.
h. Teachers at this school can be trusted.

Teacher Support (Page 3, School Questions 11 a-k): Youth perceive teachers at their school as supportive and caring about them and their academic success.

Note: Profile code assessed by percentage of "True" responses to the 6 items.
a. My teachers really care about me.
b. I get along well with my teachers.
c. My teachers really listen to what I have to say.
d. My teachers care whether or not I come to school.
e. My teachers are willing to work with me after school.
f. I receive a lot of encouragement from my teachers.
g. I am respected and appreciated by my teachers.
h. My teachers encourage me to do extra work when I do not understand something.
i. My teachers praise my efforts when I work hard.
j. My teachers care about the grades I make.
k. My teachers expect me to do my best all the time.

[2] Item "9e" was not included on this scale dimension.

School Safety (Page 4, School Questions 17 a-i): Youth attend a school with a low amount of crime and disruption.

Note: Profile code assessed by percentage of "Not a problem" responses to the 9 items.
a. Fights among students
b. Destruction of school property
c. Student use of alcohol
d. Student use of illegal drugs
e. Students carrying weapons
f. Student physically abusing teachers (hitting, pushing)
g. Students verbally abusing teachers (yelling, name calling)
h. Racial tension
i. Gang fights

Friend Dimensions[3]

Friend Support: (Page 4, Questions 1 a-e): Youth perceive their friends as supportive and responsive to their needs and feelings.

Note: Profile code assessed by percentage of "A lot like me" responses to the 5 items.
a. I can trust my friends.
b. I am able to tell my problems to my friends.
c. I get along well with my friends.
d. I feel close to my friends.
e. I can count on my friends for support.

Peer Group Acceptance: (Page 4, Questions 5 a-h): Youth feel accepted by their peers, able to be themselves, and resist negative peer pressure.

Note: Profile code assessed by percentage of "Not like me" responses to the 8 items.
a. I am afraid to do things my friends won't approve of.
b. I do things to be more popular with my friends.
c. I let my friends talk me into doing things I really don't want to do.
d. I am "made fun of" and "picked on" by my friends.
e. I find it difficult to be myself when I am with my friends.
f. I try hard to impress my friends.
g. I tend to go along with the crowd.
h. I wish my friends would show me more respect.

Friend Behavior: (Page 5, Friends Questions 7 a-i): Youth have friends who are unlikely to break the law and get in trouble with the police, who stay out of trouble, and perform well at school.

Note: Profile code assessed by percentage of "Not like me" responses to the 9 items.
a. I have friends who get in trouble with the police.
b. I have friends who use drugs.
c. I have friends who belong to gangs.
d. I have friends who drink alcoholic beverages.

[3] Friends were defined on the SSP as non-relatives from your school or community with whom you have a good relationship.

Friend Behavior – continued
e. I have friends who often cut classes.
f. I have friends who carry a weapon such as a gun, knife, or club.
g. I have friends who make bad grades in school.
h. I have friends who get in trouble at school.
i. I have friends who will probably not graduate from high school.

Family Dimensions[4]

Family Togetherness: (Page 5, Questions 1 a-g): Youth report that members of their family feel a sense of emotional closeness and bonding with one another.

Note: Profile code assessed by percentage of "A lot like us" responses to the 7 items.
a. Support one another during difficult times.
b. Give each other plenty of time and attention.
c. Talk openly and listen to one another.
d. Feel loved and cared for by one another.
e. Do things together.
f. Play and laugh together.
g. Work together to solve problems.

Parent Support: (Page 5, Questions 5 a-f): Youth report that their parents provide them with loving support and encouragement.

Note: Profile code assessed by percentage of "Often" responses to the 6 items.
During the past 30 days, adults in your home:
a. Gave you encouragement.
b. Let you know you were loved.
c. Made you feel appreciated.
d. Told you that you did a good job.
e. Made you feel special.
f. Spent free time with you.

Home Academic Environment: (Page 5, Questions 7 a-f): Youth report that their parents show an interest in their courses, experiences and activities at school and ask them about their plans for the future.

Note: Profile code assessed by percentage of "Yes" responses to the 6 items.
During the past 30 days youth have discussed the following with an adult who lives in their home:
a. Selecting courses or programs at school.
b. School activities or events that interest you.
c. Things you've studied in class.
d. Attendance, homework, or problems with a teacher.
e. Politics or current events.
f. Your plans for the future.

[4] Family was defined on the SSP as the people you live with. If you live alone, consider family as those who support you the most.

Parent Education Support: (Page 6, Questions 8 a-h): Youth report that their parents encourage and support high school performance and limit the time that they can watch TV and go out with friends on school nights.

Note: Profile code assessed by percentage of "Yes" responses to the 8 items.
During the past 30 days, adults in their home have:
a. Attended a school event in which you participated.
b. Checked on whether you did your homework.
c. Encouraged you to do well in school.
d. Limited the amount of time you could spend watching TV.
e. Limited the amount of time you could go out with friends on school nights.
f. Helped you get book or supplies you needed to do your school work.
g. Praised or rewarded you for working hard on school work.
h. Offered to help you with a homework assignment.

School Behavior Expectations: (Page 6, Questions 12 a-h): Youth perceive their parents as expecting them to do their school work, attend classes, and follow school rules and would be upset if any of the items occurred.

Note: Profile code assessed by percentage of "Very Upset" responses to the 8 items.
a. You received a D or F on your report card.
b. You cut class.
c. You turned in your homework late.
d. You were suspended from school.
e. You got in a physical fight with another student.
f. You misbehaved in class.
g. You got into an argument with a teacher.
h. You carried a weapon to school.

Individual Adaptation Profile

Personal Beliefs and Well-Being Dimensions

Social Support Use: (Page 8, Questions 20 a-h): Youth indicate that there are people they can turn to at least weekly for various types of social support and assistance.

Note: Profile code assessed by percentage of "Yes" responses to the 8 items.
a. Listen to you without giving you advice or judging you
b. Tell you that they appreciate your efforts
c. Encourage you to do well
d. Comfort you and tell you that they are on your side
e. Get you to think about your values and feelings
f. Are similar to you and see things the way you do
g. Help you by giving or loaning you money
h. Provide you with help, such as giving you a ride somewhere or helping you with your homework

Physical Health: (Page 7, Questions 6 c-g and i-k): Youth evidence good health as indicated by an absence of symptoms of physical illness.

Note: Profile code assessed by percentage of "None" responses to the 8 items.
Over the last seven days:
c. Loss of appetite[b]
d. Trouble going to sleep
e. Upset stomach/stomach ache
f. Headache
g. Nausea or vomiting
i. Dizziness or fainting
j. Other aches and pains
k. Trouble with your nerves

Happiness: (Page 7, Questions 11 a-f): Youth report general feelings of psychological well being.

Note: Profile code assessed by percentage of "Often" responses to items a, c, & e, and "Never" responses to items b, d, & f.	
Over the past seven days youth felt:	
a. Successful	(% "Often")
b. Lonely	(% "Never")
c. Pleased with yourself	(% "Often")
d. Sad	(% "Never")
e. Confident	(% "Often")
f. Feel like crying	(% "Never")

Personal Adjustment: (Page 7, Questions H14, H15, & H16): Youth report that they have not thought about running away from home, felt uncared for, or felt lost or confused.

Note: Profile code assessed by percentage of "No" responses to the 3 items.
Over the last 30 days:
H14. Have you seriously thought about running away from home?
H15. Were there times when you felt that no one cared about you?
H16. Were there times that you felt lost of confused?

Self Esteem: (Page 7, Questions 10 a-d): Youth report a sense of confidence and self worth.

Note: Profile code assessed by percentage of "A lot like me" responses to the 4 items.
a. I feel positive about myself.
b. I am satisfied with myself.
c. I am able to do things as well as most other people.
d. I have a number of good qualities.

[8] Items 6a, 6b, and 6h are not included in this scale dimension.

School Attitudes and Behavior Dimensions

School Engagement: (Page 3, School Questions 8 a-c): Youth feel that they are able to understand and manage events at school, and report they find school meaningful.

Note: Profile code assessed by percentage of "A lot like me" responses to the 3 items.
a. I find school fun and exciting.
b. I look forward to learning new things at school.
c. I look forward to going to school.

Trouble Avoidance: (Page 2, School Questions 5 a-c and g-i): Youth report that they have generally avoided getting into trouble and cutting classes or school.

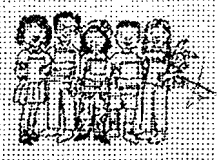
Note: Profile code assessed by percentage of "Never" responses to the 8 items.
During the past 30 days:
a. Cut at least one class
b. Cut the entire school day
c. I showed up for school late (unexcused)
d. I was sent out of class because I misbehaved.
e. My parent(s)/guardian(s) received a warning about my attendance, grades, or behavior.
g. I got in a physical fight with another student.[6]
h. I was put on in-school suspension.
i. I was given an out-of-school suspension.

Academic Performance Dimension

Grades: (Page 2, School Questions S1 & S2): Youth report at least average grades at school, and report no D's or F's on their most recent report card.

Note: Profile code assessed by responses on S1 of C's or better, and on S2 of no D's of F's.	
S1. What kind of grades did you make on your most recent report card?	(C's or better)
S2. How many D's or F's did you make on your most recent report card?	(no D's or F's)

[6] Item 5f is not included in this scale dimension.



SOCIAL SKILLS RATING SYSTEM: GRADES K-6

This questionnaire is designed to measure how often a student exhibits certain social skills. Read items 1-30 and think about this student's behavior during the past month or two. Decide how often the student does the behavior described. If the student never does this behavior, circle the 0. If the student sometimes does this behavior, circle the 1. If the student very often does this behavior, circle the 2.

For example:

	How Often?		
	Never	Sometimes	Very Often
Shows empathy for peers.	0	1	(2)
Asks questions of you when unsure of what to do in schoolwork.	0	(1)	2

This student very often shows empathy for classmates. Also, this student sometimes asks questions when unsure of schoolwork.

Please do not skip any items. In some cases, you may not have observed the student perform a particular behavior. Make an estimate of the degree to which you think the student would probably perform that behavior.

	How Often?		
	Never	Sometimes	Very Often
1. Controls temper in conflict situations with peers.	0	1	2
2. Introduces himself/herself to new people without being told.	0	1	2
3. Appropriately questions rules that may be unfair.	0	1	2
4. Compromises in conflict situations by changing own ideas to reach agreement.	0	1	2
5. Responds appropriately to peer pressure	0	1	2
6. Says nice things about himself/herself when appropriate.	0	1	2
7. Invites others to join in activities.	0	1	2
8. Uses free time in an acceptable way.	0	1	2
9. Finishes class assignments within time limits.	0	1	2
10. Makes friends easily.	0	1	2
11. Responds appropriately to teasing by peers.	0	1	2
12. Controls temper in conflict situations with adults.	0	1	2
13. Receives criticism well.	0	1	2
14. Initiates conversations with peers.	0	1	2
15. Uses time appropriately while waiting for help.	0	1	2

	How Often?		
	Never	Sometimes	Very Often
16. Produces correct schoolwork.	0	1	2
17. Appropriately tells you when he or she thinks you have treated him or her unfairly.	0	1	2
18. Accepts peers' ideas for group activities.	0	1	2
19. Gives compliments to peers.	0	1	2
20. Follows your directions.	0	1	2
21. Puts work materials or school property away.	0	1	2
22. Cooperates with peers without prompting.	0	1	2
23. Volunteers to help peers with classroom tasks.	0	1	2
24. Joins ongoing activity or group without being told to do so.	0	1	2
25. Responds appropriately when pushed or hit by other children.	0	1	2
26. Ignores peer distractions when doing classwork.	0	1	2
27. Keeps desk clean and neat without being reminded.	0	1	2
28. Attends to your instructions.	0	1	2
29. Easily makes transition from one classroom activity to another.	0	1	2
30. Gets along with people who are different.	0	1	2

The next nine items require your judgments of this student's academic or learning behaviors as observed in your classroom. Compare the student with other children who are in the same classroom.

Rate all items using a scale of 1 to 5. Circle the number that best represents your judgment. The number 1 indicates the lowest or least favorable performance, placing the student in the lowest 10% of the class. Number 5 indicates the highest or most favorable performance, placing the student in the highest 10% compared with other students in the classroom.

	Lowest 10%	Next Lowest 20%	Middle 40%	Next Highest 20%	Highest 10%
31. Compared with other children in my classroom, the overall academic performance of this child is:	1	2	3	4	5
32. In reading, how does this child compare with other students?	1	2	3	4	5
33. In mathematics, how does this child compare with other students?	1	2	3	4	5
34. In terms of grade-level expectations, this child's skills in reading are:	1	2	3	4	5
35. In terms of grade-level expectations, this child's skills in mathematics are:	1	2	3	4	5
36. This child's overall motivation to succeed academically is:	1	2	3	4	5
37. This child's parental encouragement to succeed academically is:	1	2	3	4	5
38. Compared with other children in my classroom, this child's intellectual functioning is:	1	2	3	4	5
39. Compared with other children in my classroom, this child's overall classroom behavior is:	1	2	3	4	5

Please check to be sure all items have been marked.

Appendix 4

MID-SOUTH HEALTH SYSTEMS, INC.
CLIENT AGREEMENT & STATEMENT OF CONFIDENTIALITY

Alice Baugh

CONSENT FOR TREATMENT:

I hereby give my permission for _____ to be evaluated by means of interview, psychological testing or psychiatric examining, as recommended by my assigned primary therapist. I further authorize Mid-South Health Systems, Inc., to treat said client by means of psychotherapy, counseling, behavior therapy, medication, and/or other procedures as may be indicated. It is understood that the materials and information obtained will be treated confidentially within the constraints given below.

CONFIDENTIALITY

The materials and information obtained during the course of therapy, evaluation, consultation or other mental health services will be treated confidentially by Mid-South Health Systems, Inc., subject to the following limitations: (1) unless you request release in writing; (2) your insurance carrier requests information to assist in payment for services (third-party payers such as Medicaid, Insurance, etc.); (3) valid Court order is presented; (4) information must be released by mental health professionals in response to legal requirements to report suspected child abuse or abuse of the elderly, suicidal or homicidal intent; (5) automated voice/phone equipment may be utilized to inform and remind clients of appointment schedules; (6) as otherwise required by law.

In order to assure proper confidentiality, client files are accessible only to the staff members who use the file for treatment, payment and health care operations as outlined in the Notice of Privacy Practice, review purposes and adhere to alcohol/drug confidentiality guidelines as outlined in 42 CFR Part 2. Our privacy notice provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If changed, you may receive a copy from the admission office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

FEES:

I understand that I am personally responsible for the cost of services that I will receive from Mid-South Health Systems and that I may use a third party source to satisfy my bill. In the event I am not eligible for a third party pay source, or the Center does not collect from the third party, I understand that I am personally responsible for the cost of these services. Charges will include non-direct time, such as report writing, treatment plan, interpreting tests, etc.

If I have insurance, I authorize payment of insurance benefits to go directly to the Mid-South Health Systems, Inc., and also the release of the necessary information to proceed with this claim.

AUTHORIZATIONS:

After discharge I agree to allow a representative to speak with me and/or a family member regarding the services I have received to determine my current well being. Please contact the family member listed:

Name:_____ Relationship:_____

Address/Phone:_____

I also authorize Mid-South to exchange information with my primary care physician regarding diagnosis (including drug and/or alcohol information, if applicable), intake, psychiatric evaluation, treatment plan/recommendations, current medication progress note including prescribed medications and any other relevant information that may be needed to maintain continuity of care.

Primary Care Physician:_____

Address:_____

I authorize release of any G. W. Jackson Mental Health records to Mid-South Health Systems, Inc., to maintain continuity of care.

I wish to opt out of the Notice of Privacy Practices and keep my visit and information as confidential. ____Yes ____No Initials_____

I HEREBY ACKNOWLEDGE RECEIPT OF INFORMATION PERTAINING TO THE CONFIDENTIALITY OF MY RECORDS, NOTICE OF PRIVACY PRACTICES, OUTPATIENT GUIDELINES, PATIENT HANDBOOK/BILL OF RIGHTS, THE NAME OF THE PATIENT ADVOCATE, AND AGREE TO ALL THE ABOVE.

_____	_____	_____
Client Signature	**Client Social Security Number**	**Date**
_____	_____	_____
Legal Guardian (or Parent, if minor)	**Relationship Witness**	**Date**

MSHS-1004
Revised: 2/19/03

Multi-Agency Plan of Services (MAPS) for:_____

Authorization for Release of Exchange of Information:

The purpose of this Authorization Form is to enable multi-agencies to better serve your child/adult and family through coordinated services planning and delivery. Representatives of multiple agencies will meet and share information regarding your child/adult and family to develop a plan of services to address identified needs.

I authorize the release and exchange of information between and among Team Members who will be planning services for _____ and family. This release authorizes a free exchange of information between members for coordination of services. I furthermore authorize identified representatives to pursue services on behalf of my child/adult and family.

_____	_____	_____
Authorizing Signature	Relationship	Date

_____
Witness

Confidentiality Statement and Cooperative Agreement:

As members of an interagency service planning development team, we will review confidential information on children/adults and families referred to the team. In carrying out this network of services and case planning, the agencies and persons below commit to work cooperatively together and to keep confidential all information disclosed.

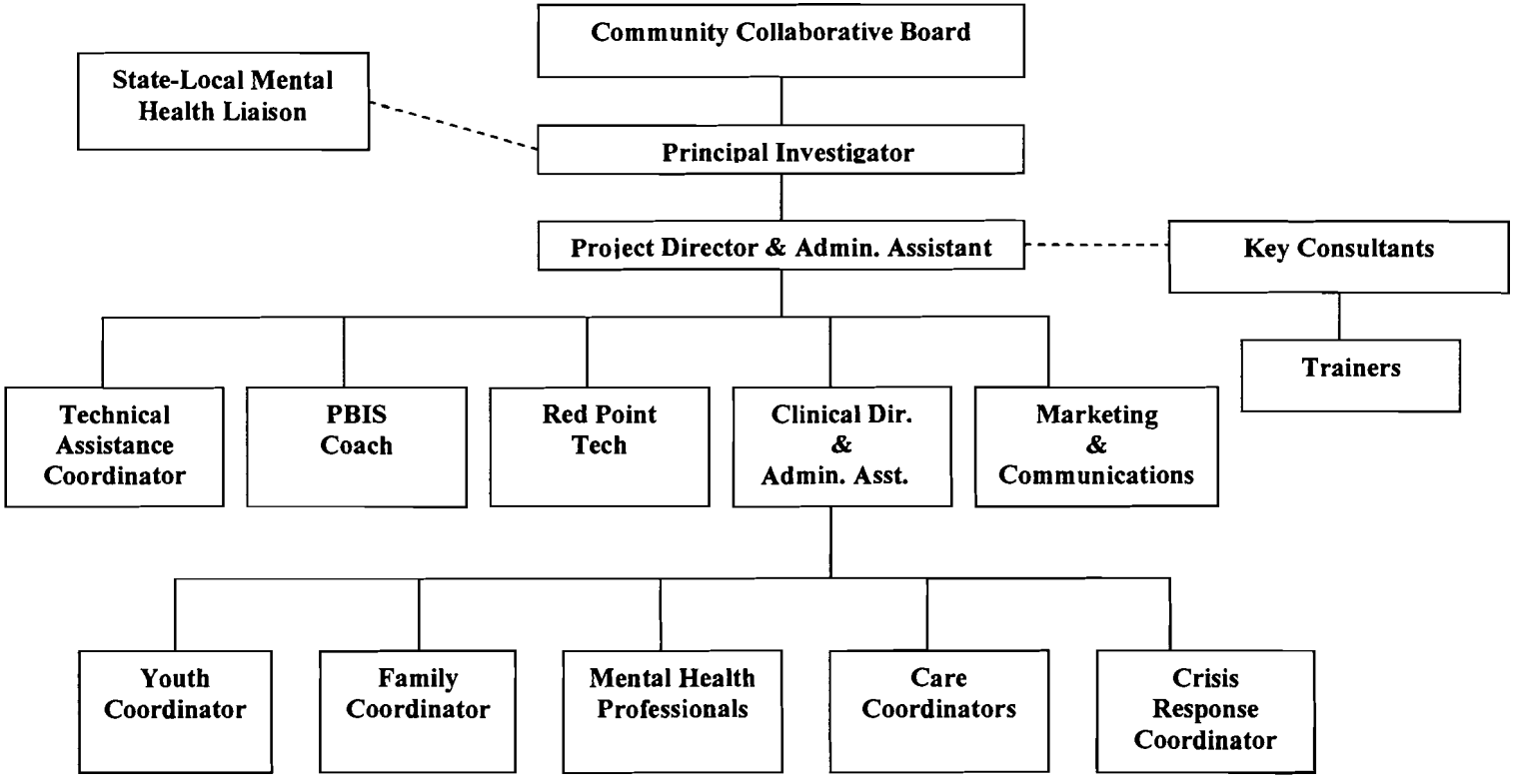
Name	**Agency**	**Date**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

"Non-Federal Match Certification"

I certify that non-federal matching funds for the Craighead County Connections for Kids Project are available and will be provided by Mid-South Health Systems and that changes in funding streams required for the non-federal match and other funding innovations necessary for implementation of the project will be allowed and supported.

CRAIGHEAD COUNTY CONNECTIONS FOR KIDS

Organization Chart



TIMELINE

Funding Year	Main Task	Person Responsible
Year 1	Develop Community Advisory Board	Bonnie White, Principle Investigator
	Hire Key Personnel	Community Advisory Board
	Train Key Personnel	Alice Baugh, Project Director
	Create Six-year strategic plan	Community Advisory Board Alice Baugh, Project Director Ann Wells, State Liaison
	Develop six-year technical assistance and training activities plan	Derek Spiegel, Technical Assistance Coordinator Alice Baugh, Project director
	Develop a plan to increase school-based mental health services	Sharon Travis, Clinical Director
	Develop approach for services integration and coordination	Alice Baugh, Project Director Community Advisory Board
	Establish guidelines for Care Teams	Sharon Travis, Clinical Director
	Develop local chapter of the Federation of Families	Pam Marshall, Family Consultant Martha Lewis , Family Coordinator
	Implement activities for family involvement, youth involvement and cultural competency	Pam Marshall, Family Consultant Martha Lewis, Family Coordinator Youth Coordinator
	Build the Capacity to enhance the National Evaluation	Dr. David Saarnio, ASU, The Center for Social Research and Evaluation
	Technical Training and assistance in the schools for the RedPoint software program	Red Point Consultant
	Train PBIS coaches	Marilyn Copeland, PBIS Coach
	Develop a Social Marketing Plan	Jayni Blackburn, Matt Knight, Social Marketing Team
	Work with Key Consultants	Marty Hydecker, Mental Health Pam Marshall, Family James Mason, Cultural Competency
Year 2	Hold Quarterly Community Advisory Board Meetings	Bonnie White, Principal Investigator
	Hire additional Care Managers, Therapists, etc.	Sharon Travis, Clinical Director
	Train new employees, and provide continuing education activities for existing employees	Alice Baugh, Project Director
	Implementation of the System of Care (i.e., Connections for Kids)	Alice Baugh, Project Director

		Sharon Travis, Clinical Director Derek Spiegel, Technical Assistance Coor.
	Begin to enroll children and their families	Alice Baugh, Project Director Marilyn Copeland, PBIS Coach Crisis Response Coordinator
	Incorporate Wraparound Model	Alice Baugh, Project Director Derek Spiegel, Technical Assistance Coordinator
	Incorporate families and youth into the evaluation process	Dr. David Saarnio, ASU Martha Lewis, Family Coordinator
	Implement RedPoint in First Cadre of schools	
	Implement PBIS in first cadre of schools	Marilyn Copeland, PBIS Coach
	Implement Social Marketing Plan	Jayni Blackburn, Matt Knight, Social Marketing Team
	Work with Key Consultants	Marty Hydecker, Mental Health Pam Marshall, Family James Mason, Cultural Competency
Year 3-6	Continue to hire additional staff.	Alice Baugh, Project Director Sharon Travis, Clinical Director
	Continue revision of the Connections for Kids as determined by local and National Evaluations	Dr. David Saarnio, ASU
	Incorporate Wraparound Model	Alice Baugh, Project Director Derek Spiegel, Technical Assistance Coordinator
	Incorporate families and youth into the evaluation process	Dr. David Saarnio, ASU Martha Lewis, Family Coordinator
	Implement RedPoint in First Cadre of schools	
	Implement PBIS in first cadre of schools	Marilyn Copeland, PBIS Coach
	Implement Social Marketing Plan	Jayni Blackburn, Matt Knight, Social Marketing Team
	Work with Key Consultants	Marty Hydecker, Mental Health Pam Marshall, Family James Mason, Cultural Competency
	Develop strategic plan for sustainability	Community Advisory Board Bonnie White, Principal Investigator
	Develop a plan for replication across the seven county mental health service area and throughout the state.	Community Advisory Board Bonnie White, Principal Investigtor

OMB Approval No. 0348-0040

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with com- mission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub- grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dis-pensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about--

(1) The dangers of drug abuse in the workplace;
(2) The grantee's policy of maintaining a drug-free workplace;
(3) Any available drug counseling, rehabil-itation, and employee assistance programs; and
(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement re-quired by paragraph (a), above, that, as a condition of employment under the grant, the employee will--

(1) Abide by the terms of the statement; and
(2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point

for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These require- ments apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical an mental health of the American people.

"Non-Supplantation of Funds"

It is understood that funding under this program is intended to support new or enhanced projects, therefore, we certify that Federal funds will not be used to supplant/replace funds already committed.