SECTION A: UNDERSTANDING THE PROJECT

1. Project Overview

The Illinois Department of Human Services/Division of Mental Health (IDHS/DMH) is strongly committed to expanding of Systems of Care (SOC) in Illinois. Champaign County began investing in SOC in 2002 by consulting with professionals in system building and culturally and linguistically competent mental health practices, and has added some components each year since that time. In 2005, the Project ACCESS (Agencies of Champaign County Engaging in Systems of Services) cross-agency collaboration was formed to address the unmet needs of youth and families in the community. Since that time, Project ACCESS has remained committed to transforming the service system into one that is more family-driven, youth-guided, and culturally and linguistically competent – and includes partners from relevant youth-involved systems and the community, including parents, grandparents, youth, caregivers, faith leaders, aunties, uncles and trusted family friends; partners from the justice system, mental health system, welfare system and education system; community based youth- and family-serving agencies; Advocacy and mentoring programs for youth and families; and the University of Illinois, Urbana-Champaign.

With the support of the Champaign County Mental Health Board (CCMHB), the local funding body, and McHenry County Family CARE, a 2005 CMHI site with whom we have consulted, Project ACCESS developed a pilot program to serve youth at the county juvenile detention center (JDC) who have mental health needs. This JDC Pilot Project has enabled us to create, test, and refine system-wide procedures, forms, and structures. The current proposal, which will be referred to as the **ACCESS Initiative**, involves a partnership between Project ACCESS and IDHS/DMH to expand the JDC Pilot Project to serve youth with serious emotional disturbance (SED) county-wide. This expansion will have a particular emphasis upon youth with SED involved in (or at risk for involvement in) the juvenile justice system and African American youth, who are disproportionately represented in the county's child-serving systems. The ACCESS Initiative, which has involved the voice of youth, families and relevant stakeholders throughout the process, has the following goals at the center of the SOC transformation:

a) to expand the community and system capacity to address the needs of the targeted population, through the expansion of **accessible, culturally and linguistically competent**, **effective treatments**, and through the expanded use of natural and existing community supports;

b) to transform the county's Social service infrastructure, both fiscally and in terms of philosophy, so that services for each youth follow an individualized, family and youth driven plan which best fits the culture and values of the family, and so that this infrastructure is sustainable over time;

c) to serve as a replicable model and catalyst for SOC expansion, regionally and statewide, as part of the state's efforts to expand SOC in Illinois and to reduce the stigma for mental health services for youth and families.

2. Geographic Service Area (Champaign County, IL)

Champaign County, located south of Chicago in East Central Illinois, has a population of 187,000, of which approximately 77% are European American, 8% Asian, 4% Latino/a (of any race), and 12% African American.. The county includes thriving urban areas (e.g., the twin cities of Champaign and Urbana), rural towns, a community college, two major health care systems, a low unemployment rate, strong communities of faith, an impressive self-help network, the

resource rich University of Illinois campus, a broad array of human service agencies, and a progressive justice system. The county is also home to youth and families struggling with the burdens of poverty, mental illness, and family instability. For instance, school districts identify 35% of children as low-income, with higher rates in some areas, such as Urbana (52%), and Rantoul (68%). Almost 1500 children in the county are estimated to have or to be at risk for an SED, and 5% of children aged 5-15 have a reported disability (2007 American Community Survey). Partially due to the University of Illinois campus, the county has the highest education level per capita in the nation; however reading and financial literacy deficits are still reported as barriers to workforce development by Parkland College. Of the approximately 20,000 households with children under age 18 in the county, one-fourth are headed by single-parents. African American youth and families are disproportionately affected by most of these challenges.

3. Population

a. SED Prevalence for Youth in the County - Given the 9% SED national prevalence rate for youth aged 10-17, we would expect approximately 1,500 youth out of 17,000 youth aged 10-17 in our county to have serious mental health needs (Friedman et al., 1996). There is evidence, however, that the SED prevalence rate in Champaign County is above average. For instance, Crosspoint Human Services, which is the local provider of the Screening Assessment and Support Services (SASS), the mental health crisis program for children, is highest in call volume outside of the Chicago area (out of 55 providers statewide).

b. Targeted Population and Disproportionality **-** The ACCESS Initiative targets youth aged 10-17 with SED and/or multiple system involvement, and who are at risk for or involved in the juvenile justice system. We plan to create an infrastructure that is particularly responsive to African American youth and families because they are disproportionately living in poverty, receiving special education services, involved in child welfare, and experiencing family instability, mental health difficulties, and health challenges. In addition, African American youth are significantly over-represented in the justice and school disciplinary systems. For instance, the county's 2700 African American youth are16% of the total youth population, but African Americans youth make up 43% of child welfare and 53% of foster care recipients, 78% of Juvenile Detention Center (JDC) admissions, 50% of youth placed on station adjustment by law enforcement, 66% of youth on probation, and over 60% of school suspensions. African American males are particularly at risk, accounting for over 65% of JDC admissions and 42% of school suspensions, although the county is currently beginning to address the rising number of girls in the system (e.g., through the Girls Advocacy Project). In addition, African-American youth and their families have indicated in focus groups and surveys that local service systems are not responsive to their needs, also creating disparity in terms of access to quality care.

c. Referrals to the ACCESS Initiative **-** Referrals to the program will come through multiple points of entry, including juvenile justice, schools, physicians, public health, faith-based services, the Local Area Network, and SASS. Representatives from each of these areas and from 18 local agencies serving youth and families have been working in close collaboration since 2002 as part of Project ACCESS. The Juvenile Detention Center had 246 unduplicated admissions in 2007. Based on mental health screenings conducted at the JDC through the Mental Health-Juvenile Justice (MH-JJ) program, which uses standard clinical cutoffs for an SED diagnosis, it is expected that 40 youth annually will be referred to the program directly by the JDC. It is estimated that annually over 2000 referrals will come from schools (e.g., suspensions and expulsions), mental health providers and community-based youth services (e.g., Don Moyers

Boys and Girls Club), approximately 50 from juvenile officer station adjustments and 300 through SASS from crisis calls.

4. Current Capacity

a. Services for Youth with SED **-** While there are gaps in the current service capacity of Champaign County, and disproportionality in how youth are served, the county does have a wealth of human resources which can be harnessed by a well implemented SOC. Counseling and psychiatric services are offered by a number of Project ACCESS partners. For instance, the Mental Health Center, the county's largest provider of mental health services, serves about 1,500 children annually, with about 700 of these receiving psychiatric services. Crosspoint Human Services, the local provider of the statewide SASS mental health crisis services for children, serves 360 youth annually using individualized service plans. The University of Illinois' Psychological Services Center (PSC) offers specialized services for about 50 youths per year, such as neuropsychological assessments, individualized counseling for adolescents with SED and Brief Family Therapy for families with a youth experiencing SED. Community-based and family-centered services involving care coordination, Family Decision Making, family and youth mentoring, and family and youth Advocacy are also offered by a number of Project ACCESS partners, such as PSC (261 youths/families last year), Best Interest of Children (80), TALKS Mentoring (345), Don Moyers Boys and Girls Club (160), Operation Snowball (100) and the Local Area Network (13). Without a SOC central intake process it is possible for duplicate service counts among providers; however current capacity for serving youth with SED is over 2000.

b. Care Coordination **-** In 2006, Project ACCESS developed a pilot program to serve youth at the Juvenile Detention Center, which tightly integrates programs of eight agencies in response to the well-established needs of SED youth for a range of mental health services at varying intensity levels (Stroul & Friedman, 1994). Eligible youth at the detention center are assessed for potential mental health problems with the MAYSI (Massachusetts Youth Screening Instrument) and CSPI (Childhood Severity of Psychiatric Illness) and offered the option of care coordination. Agencies involved in the Pilot use uniform enrollment and release of information forms, and data is centrally tracked via a biweekly report entered into a database. Pilot-enrolled youth are offered a variety of services: screenings; assessments; care coordination at levels of intensity varying from case management to Family Group Decision-Making and Wraparound; 24-hr crisis services; individual and group counseling; 90-day crisis support services; a community-based day and evening reporting center; substance abuse groups; family consultation; mentoring; and referrals and linkages to other services, including non-traditional and faith-based services. In 2007, the Pilot served 248 unduplicated youth (70% African American) and had a 17% recidivism rate.

The Champaign County Mental Health Board (CCMHB) has brought nationally-recognized professionals (e.g., Dr. Harry Shallcross and Dr. Carl Bell) to work with community agencies on system development and cultural competence. The CCMHB has emphasized cultural competence and inter-agency collaboration as core components of all locally-funded projects by prioritizing these areas in funding decisions (e.g., requiring a cultural competence plan in funding applications). Project ACCESS participated in the National Wraparound 2007 *Community Supports for Wraparound Study* which showed the county to be poised for change. Specifically, data showed strengths with respect to collaboration, communication, youth voice,

and community involvement, but also identified structural barriers that will be addressed by this proposal.

c. Youth and Family Involvement **-** Current youth representation has developed from the Peer Ambassador program (Mental Health Center). The Peer Ambassadors (whose current membership is 100% African American) regularly attend and participate in Project ACCESS planning meetings, have conducted community forums on topics of concern to youth, and have led study groups with youth at the detention center. Peer Ambassadors have become regionally and nationally recognized for their work, presenting at the 19th annual National Federation of Families for Children's Mental Health conference and before state and local bodies. They have also been invited to participate on the National Youth Advisory Board being established by the Systems of Care national evaluation team and on the Illinois Area Youth Council for Leadership development. Peer Ambassadors have taken an integral part in decision making for the JDC Pilot program and have participated in the visioning of the proposed ACCESS Initiative and the SAMHSA application. The ACCESS Initiative will build on Peer Ambassadors to create a Youth Advisory Board.

Family and caregiver involvement in Project ACCESS, the JDC Pilot and the preparation and visioning of this application has been consistent. Family representation comes from a number of active family groups, including Parents As Partners (a movement that recognizes parents as professionals with respect to their own families, children, and communities), the Parent Advisory Committee (a joint venture between Project ACCESS, Parents As Partners, LAN #24, and Crosspoint Human Services), which meets monthly and provides family-focused advice to service providers and other family groups. With funding from the Mental Health Board and the support of statewide partners such as the Illinois Federation of Families for Children's Mental Health and NAMI, the ACCESS Initiative will incorporate participation of these family members in all aspects of the SOC.

d. Community Involvement - Project ACCESS has worked with *Why We Can't Wait*, a local coalition of African American faith based leaders, educators, advocates, community leaders and service providers. The mission of *Why We Can't Wait* includes increasing the African American community's capacity for appropriately, sensitively, and proactively responding to the needs of African American youth and families with the goal of a healed and thriving African American community. The vision and findings of *Why We Can't Wait* have been integral to the proposed ACCESS Initiative, and in the articulation of the challenges faced by the African American community from an African American perspective.

5. Gaps, Inadequacies and Barriers to Services

While the provider community has shown a sustained commitment to SOC development and a willingness to work together collaboratively to help youth involved in the JDC, we are still far short of the vision of a seamless, family-driven, culturally and linguistically competent, effective and efficient SOC. Critical barriers, gaps and inadequacies identified by key stakeholders, especially youth and families, highlight the significant need for a SOC transformation in the county, and reflect the main goals of the proposed ACCESS Initiative.

a. Community Capacity - Since May 2007, the Peer Ambassadors, the youth voice of Project ACCESS and this proposal, have brought together youth at the JDC and local law enforcement officials to participate in a series of meetings regarding youth involvement in the justice system. Using the Search Institute's 40 Developmental Assets, they have identified several unmet needs contributing to the detention of large numbers of (particularly African American) youth in the

county, including lack of positive peer interactions and teen-oriented activities in the community; gaps in the educational system (e.g., poor disciplinary policies, lack of connection with teachers); absence of a sense of safety and support in their neighborhoods; and lack of accountability for their choices within their families.

Similarly, the *Why We Can't Wait* coalition has identified a number of core issues which have led to the current crisis of African American youth and families in the county, several of which relate to the issue of community capacity and echo youth perspectives, including alienation from the educational system; poverty; family instability; the personal internalization of oppression; lack of self-Advocacy within the African American community; abandonment of the community by upwardly mobile African Americans; and collective silence.

These critical gaps are addressed in goals of the ACCESS Initiative to expand the community's capacity to address the needs of targeted youth through a strength-based Wraparound with partnerships among families, agencies and funders.

b. Services for Targeted Population -While Champaign County boasts a rich array of services for youth with SED (and their families), the targeted population consistently reports that a lack of culturally competent providers and an absence of need-based services prevent current services from being effective and contributes to under-utilization of preventive and mental health services by African American youth. Data from a 2007 survey of parents of children with SED receiving services in the county (distributed through the Project ACCESS *Parents As Partners* mini-conference) describe a number of inadequacies and barriers. Over 75% of parents reported a lack of trust in the system, over 90% said that service providers were not "welcoming" and that the bureaucracy (e.g., paperwork, steps to be taken) was too burdensome, 80% reported that providers did not have enough time for them, and only about 10% said they could usually pick the provider they wanted for their child.

Why We Can't Wait has identified a number of inadequacies in the current service provision system for African American youth and families that echoes these data, concluding that the system continues to be unresponsive to the needs of people of color, and that a historic and current mistrust of the system by African American families continues to be a barrier to effective engagement and treatment.

Findings about system mistrust and a negative pre-disposition towards services are supported by outcome data from the JDC Pilot, which shows the biggest weakness in the Pilot to occur at the family engagement stage. That is, case managers encountered significant challenges in recruiting and engaging parents and caregivers into the Pilot. In addition, there is lack of coordination among mental health, primary health, school and other child-serving systems to address all life domains with coordinated services.

These reported inadequacies, together with the disproportionality statistics for child involvement with child welfare and juvenile justice in the county, drive another major goal of the ACCESS Initiative, *i.e.,* the transformation of the system to be more culturally and linguistically competent, driven by youth and family needs, and de-stigmatized.

c. Fiscal Infrastructure - Because the county currently lacks a collaborative funding structure in which funding follows the child/family, agencies and programs in the county continue to serve youth and families in *cooperation* with each other while simultaneously competing for funding. This issue was highlighted by the National Wraparound Initiative's 2007 *Community Supports for Wraparound Study,* which found Champaign County to have significant capacities for a SOC transformation, with structural inadequacies being a major current barrier. The transformation of

the county's mental health and social service system funding strategies to better respond to individual youth needs is addressed as one of the goals of the ACCESS Initiative.

6. Collaboration with other Federal, State and Local Programs

The ACCESS Initiative is currently collaborating and/or plans to collaborate with federal, state, and local programs and reform initiatives as follows:

a. Integration into Statewide Programs - The ACCESS Initiative will more fully integrate with two statewide programs already connected to the JDC Pilot. Screening, Assessment, and Support Services (SASS), operated by the Illinois Department of Human Services Division of Mental Health (IDHS/DMH) provides 90-day crisis services for youth at risk of hospitalization due to serious mental health issues (including screening, deflection, and after-care) and is a core component of McHenry County's Family CARE, which will provide technical assistance in the integration of SASS services into Project ACCESS. Mental Health-Juvenile Justice (MHJJ) is an initiative available in all Illinois counties with juvenile detention centers and uses the CSPI and CANS assessments, Wraparound plans, and flexible funding to serve youth in detention with severe mental illness. Since McHenry County lacks a MHJJ program, it is important to IDHS/DMH to see that the MHJJ initiative is integrated into the Champaign system of care.

Other DMH programs associated with the project include Youth Transition Services, community-based outpatient services, and the Individual Care Grant program for Mentally Ill Children (ICG-MI) for youth in need of residential treatment services. Project ACCESS has also collaborated with the Illinois Department of Children and Family Services (IDCFS) and the Administrative Office of the Illinois Courts (AOIC) pertaining to youth with SED. It should also be noted that the Champaign County Mental Health Board has the authority to receive Medicaid reimbursement for services (Part 132 – Medicaid Community Mental Health Services Program) as delineated in an intergovernmental agreement with the Illinois Department of Healthcare and Family Services, the state Medicaid agency. The ACCESS Initiative will build on these relationships for better coordination among the state's child-serving agencies.

b. Collaboration with Juvenile Reform Efforts - In fall 2007, Project ACCESS representatives attended a statewide conference aimed at unifying five juvenile justice transformation initiatives in Illinois. Expansion of these initiatives into Champaign County was cited by conference organizers as a priority. Similarly, local justice and Project ACCESS leaders, such as Connie Kaiser (Juvenile Detention Center Superintendent) and Joe Gordon (Court Services Director), will continue to work with their national peers on bringing evidence based practices that have worked in other JDCs into the local Initiative (e.g., Parenting with Love and Limits). Conversely, as the SOC transformation in the county takes place, the Initiative can begin to serve as a model for best practices among Juvenile reform efforts in the state and nation.

c. Linkages with Statewide Reform Efforts - Both of the Co-Principal Investigators identified in this proposal are gubernatorial appointed members of the Illinois Children's Mental Health Partnership, convened in 2003 to assess and recommend changes for the provision of mental health services to youth in Illinois. Their involvement in a SOC transformation over the six years of the cooperative agreement and beyond will allow them a unique opportunity to bring the SOC philosophy, best practices, and process to leaders of every major state division concerned with children's mental health, including the Directors of Child Welfare, the State Board of Education, the Department of Human Services Divisions of Mental Health, Community Health and Prevention, Substance Abuse, Developmental Disabilities and Early Intervention, and the Department of Juvenile Justice. The State/Local Liaison and Family Organization advocates will focus these efforts for sustainable change.

***d. Collaboration between Local Programs and ACCESS Initiative* -** One of the strengths of Project ACCESS has been its comprehensive inclusion of, and collaboration with, diverse county consortia, programs, grassroots organizations, government agencies, African American agencies, schools and initiatives that serve youth and families. Through the full time Cultural and Linguistic Competence Coordinator, the ACCESS Initiative plans to collaborate even further with groups that work to address the needs of other under-represented populations, such as PFLAG (Parents, Family and Friends of Lesbians and Gays), the Latino Partnership, faith-based organizations and PACE Independent Living Center (for people with disabilities).
e. Statewide Replication Efforts - Project ACCESS has benefited from consultations with McHenry County Family CARE (funded under CMHI in 2005) and other CMHI sites and will continue to do so under the ACCESS Initiative. Similarly, the ACCESS Initiative plans to serve as a mentor to neighboring Vermilion County, partnering with them to create a SOC. Project ACCESS partners have joined Prevention First, a non-profit that sponsors an annual statewide cultural competency conference, to develop a statewide cultural competency plan, and the ACCESS Initiative will continue this mutually beneficial collaboration. Materials developed through the ACCESS Initiative will be posted for Internet access by other developing SOCs.

SECTION B: IMPLEMENTATION PLAN

B1: INFRASTRUCTURE DEVELOPMENT

The ACCESS Initiative is dedicated to completing the shift from a program based approach to a family-driven, youth-guided, care management approach that individually addresses the needs of each child across all life domains. Families and youth from the target population have participated in Project ACCESS from its inception and have taken a meaningful role in envisioning how the transformation to a SOC will occur, including infrastructure and governance. The JDC Pilot, with significant family and youth involvement, has helped to develop and refine infrastructure that can be expanded and strengthened with additional funding. Currently, the pilot uses common enrollment and release of information forms and maintains a database capable of tracking enrollment, confidentiality, and demographic information, family engagement levels over time, and case updates. Communication channels among participating partners and care coordination standards are in place and regularly reviewed. The ACCESS Initiative plans to significantly shift the fiscal infrastructure in the county, pooling Mental Health Board money to help fund SOC development while incorporating ways to sustain the system (e.g., creating Medicaid billable services that can be requested by families as part of their Wraparound service array). The Initiative will utilize consultations with current CMHI funded sites and *Building Systems of Care: A Primer* to help with the continued expansion and development of the local system.

1. Governance Structure

The Governing Board, which will have primary responsibility for policy development and fiscal decision-making for the ACCESS Initiative, will consist of 9 key stakeholders, at least 5 of which will be family and youth members from the targeted population, including the Lead Family Contact, Youth Coordinator, two other family/youth representatives and one family/community member, as well as one representative each for child welfare, mental health, juvenile justice and education. The Governing Board, through the ex-officio member Project Director, will elicit regular input from administration, care and evaluation teams, the State/Local

Liaison and the co-PIs. Representatives of the Youth Advisory Board (YAB) and the Family Organization (FO), will serve as liaisons between the Governance Board and their respective constituents regarding the strategic plan, cultural and linguistic competency plan and social marketing plans, will make recommendations to the Mental Health Board with respect to local funding decisions, will offer venues for leadership and Advocacy development and will have a public relations role for the ACCESS Initiative (see Appendix for Organization Chart and Management Chart).

2. Governance Process - By-laws for the governance body will be developed early in Year 1 with full input from families and youth. All governance participants will be trained on engagement in the civic process through vehicles such as collective problem solving, resource management, asset mapping, collaboration, decision-making, and power sharing. The by-laws of the governance body will be designed to permit structural changes in recognition that the group should define itself and may need to change in response to project needs. Meetings of the governance body will be held at least monthly in Year 1 and quarterly thereafter. Quorum rules will require that youth and family members be the majority present for any voting issue. Particular effort will be taken to ensure that the participation of family, youth, and members of other traditionally under-represented groups (e.g., the LGBTQ community, people with disabilities) will be meaningfully and fully integrated into project governance. The Cultural and Linguistic Competence Coordinator will help ensure that meetings of all governing groups will be conducted in a culturally and linguistically competent manner through review of literature and documents for issues related to language and literacy; consumer-friendly meeting formats, locations, and times; use of incentives to help family and youth participate in meetings; and active facilitation of meetings to ensure meaningful participation of family, youth, and other participants. Issues of accessibility will be addressed through the provision of translators and interpreters and accommodations will be provided for members with disabilities, including those with physical, visual, hearing, learning, and other disabilities.

3. Procedures for Integration, Collaboration, Development and Support
The JDC pilot has served as a testing ground for the system integration initiatives. As envisioned with input from families and youth, consumer access to the system will be facilitated through referral and enrollment at all identified intake points. Intake staff will conduct screenings at agencies and community locations. The ACCESS Initiative will use the Wraparound and Advocacy models to create strength-based, family-driven, individualized Plans of Care, and care review will fall under the Initiative's system-wide Quality User Assurance and Grievance Implementation process (QUAGI), which incorporates ongoing findings from the Evaluation team and a Complaint and Grievance procedure following guidelines established by the Department of Health & Family Services/HFS 94 – Patient Rights and Resolution of Patient Grievances. The Champaign County Mental Health Board (CCMHB) will provide flexible funding under the current proposal. Additional funding will come from DHS, DCFS, Medicaid reimbursement, grants, and local fundraising activities. Early in Year 1, a strategic plan will be developed to align funding with ACCESS Initiative objectives. Members of the Family Organization and the Youth Advisory Board, will be recruited, encouraged, and supported to take on leadership and provider roles within the SOC. Based on input from current families and paraprofessionals, the Initiative will also take steps to facilitate the professional development of traditionally underserved individuals (e.g., African American parents) by creating entry level

positions into the system which allow for growth over time. The Initiative will also promote cross-training among partners to increase local capacity.

4. System of Care Replication and Fiscal Integration into Statewide Initiatives
The ACCESS Initiative will continue to pursue statewide children's mental health initiatives and funding, such as SASS (Screening Assessment and Support Services); MHJJ (Mental Health Juvenile Justice Initiative), which has been successfully utilized in collaboration with the JDC Pilot; Individual Care Grants for Mentally Ill Children (through SASS); community service block grants (DCEO) through the Regional Planning Commission, and flexible funding through the LAN. Linkages between key Initiative partners and statewide children's mental health policymakers (including the State/Local Liaison) will be used to disseminate information, advocate for statewide SOC transformation and provide assistance to counties ready to move towards SOC. Current linkages include the Illinois Children's Mental Health Partnership (both co-PIs), the Administrative Office of Illinois Courts (through Joe Gordon) and the Association of Community Mental Health Authorities of Illinois (through a number of Project ACCESS Partners). Neighboring Vermilion County will take advantage of our knowledge, practices, and expertise in preparation for SOC replication there and replication will be explored statewide by IDHS/DMH. The ACCESS Initiative will continue to exchange information, data, and lessons learned with other CMHI sites (e.g., McHenry County Family CARES). For instance, Dr. Jorge Ramirez, an ACCESS partner, served as a cultural competence consultant for Family CARES in 2006, while ACCESS consulted with them about the JDC Pilot in 2007. Other linkages include Lisa Massa (DCFS), Amy Starin (DHS/DMH and Illinois State Board of Education).

5. Strategies for Developing System of Care Structures
The clinical network will be enhanced and expanded by increasing use of evidence based and practice based interventions, increasing provider cultural and linguistic competence, and building capacity through inclusion of natural supports and assisting additional independent practitioners in the community to access trainings, certification, licenses, and Medicaid billing capability. The ACCESS Initiative's administrative team will be led by the Project Director and be composed of core project staff and consultants as needed, including under-represented groups (e.g., African American, LGBTQ, non-native English speakers). The team will work closely with the co-PIs, evaluation staff and care team to draft a six-year strategic plan and implement policies set by the governing body.

A training team led by the Technical Assistance Coordinator and including interagency, family and youth participation, will be established in Year 1 to identify training needs and implement appropriate cultural competence, SOC, leadership, Wraparound, Advocacy and other training activities for staff, parents, youth, and volunteers. Building upon existing training resources, cross-training among agencies and using "train the trainer" and "train the leader" models will ensure sustainability. The board and administrative team will work with the evaluation team to develop performance standards to assess child and family outcomes, service capacity and accessibility, learning of and adherence to SOC principles, level of collaboration among agencies, parent and youth involvement, cultural and linguistic competence, and consumer satisfaction. Specific procedures for care review and grievance procedures will also be established. An MIS consultant will expand the database developed for the JDC Pilot to add a provider database for supporting decisions in strategic planning and care provision. Family, youth and the evaluation team will ensure data is useful for system planning and decision-making. Data will be stored in

compliance with HIPAA, and secure web-based access will improve appropriate inter-agency accessibility.

Through a partnership with the Champaign-Urbana Public Health District (CUPHD), the ACCESS Initiative will maintain ADA compliant office and service-delivery space in approximately 13,000 square feet adjacent to the public health facility. To address accessibility issues, as requested by families in planning of the Initiative, this space is located in a predominantly low-income and African American area, is close to a Federally Qualified Health Center and is convenient to a major highway interchange. Families will help design this space.

6. Plans to Collaborate with Other Child-Serving Systems

The ACCESS Initiative will continue to expand upon collaborations with other systems through work groups, contracts and Memoranda of Understanding (MOUs). Champaign County Probation and Court Services is already a full partner with Project ACCESS (including an MOU), and extensive meetings with police departments, the State's Attorney, and the Public Defender have taken place to discuss program expansion under the ACCESS Initiative. The Regional Office of Education has joined with Project ACCESS to coordinate truancy services, and a School-Agency Collaboration Working Group is developing strategies for seamless service delivery and transition services for students.

An MOU with the Child and Adolescent Local Area Network #24 (C&A LAN) has made cooperative care plans possible between Project ACCESS and DCFS. The Initiative also partners with DCFS to work with Saving Our Families Together Today (SOFTT), a new DCFS/community workgroup addressing the disproportionate representation of African American children in foster care. In addition to both central and outreach locations, Project ACCESS and Champaign-Urbana Public Health Department plan to deliver mental health services through CUPHD's mobile health clinics which travel county-wide. CUPHD will also broker relationships with other health care providers and provide a community office space for the ACCESS Initiative. Our community, faith-based, and school collaborations will be strengthened through School and Community Resource Developers, building on lessons learned from McHenry County Family CARE. Project ACCESS MOUs with child serving agencies and community leaders and other relevant stakeholders, are included in Appendix 1. Other focused MOUs and contracts will be created to implement services, supervision, and other infrastructure components (e.g., MIS administration) in the planning year.

7. Training and Technical Assistance

The Technical Assistance Coordinator will work with a team of families, youth, system partners and staff to identify and address the training needs of the SOC. See examples in Table 1 below.

Table 1: Training and Technical Assistance Plan (Examples)

Topic	**Description and Targets**	**Strategies**
Cultural and Linguistic Competence	Orientation & Training for all participants; Required for board, staff & providers	Sustainability built through: -“Train the Trainer” -“Train the Leader” - Use of local cultural coaches
Wraparound and Care Coordination	Orientation, Training and Certification (20-40 hrs) offered to providers and supervisors at least 4x/yr first 3 yrs; Required for Care	Consultants will include: -Janet Walker (NWI) -Collette Luck (Chicago)

	Coordination Team	-Lucile Eber (PBIS) -Peer review
SOC Principles ("System of Care 101")	Training for all staff, stakeholders, partners and participants 2x/yr at first; then annually; required of all providers; Required partner orientation offered monthly	Consumer friendly, presented by families & youth as part of social events ("meet & greets," bowling night)
Evidence Based Interventions	Orientation & training for all system participants; required for all staff and Care Coordination Team	Families & youth involved in evaluation of all EBPs being considered; cross-training among agencies
Advocacy Model	For Family Advocates, School & Community Resource Developers, and Youth Advisory Board members	Using manual developed in Michigan & modified locally by G. Hunt
Family and Youth Organization Development	For consumers, families, youth (*Peer Ambassadors*, *Parent to Parent*, *Parents as Partners*, & *Walk the Talk)*	Support and tech. assistance from IL Federation of Families, NAMI, & National Youth M.O.V.E.
Data Management and MIS	For all relevant stakeholders (e.g., providers, Care Team, supervisors, staff)	Data management, record keeping, releases, HIPAA, billing, etc.
Governance Process	Orientation & training for all governance members	Use materials from *board café* as part of every meeting

8. Social Marketing Strategies

Comprehensive Social marketing strategies will be created in Year 1 by a team of interagency representatives, family members and youth, led by the Communications Coordinator. Objectives will include providing information about the ACCESS Initiative, SOC, and community resources; reducing stigma attached to mental health issues and services; fortifying the positive self-image of the target population, and, in particular, of low-income African Americans; educating the public about the needs of SED youth; recommending good mental health practices; and developing broad-based community support for the project. Focus groups with youth and family members, and consultations with under-represented community groups (e.g., GLBTQ, immigrant community), *Say It Out Loud*, Vanguard Communications and CMHI funded sites, will help shape media materials (e.g., radio, TV, and print; posters; flyers, website content), both in English and Spanish and with attention to literacy levels of intended audiences. Collaborations will include NAMI, Public Health, the Illinois Federation of Families and the national SAMHSA media office. Based on family input, beauty shops, bus stations, laundromats, libraries, churches, and meeting halls will serve as message venues and recent marketing activities will be expanded (*e.g.,* a call-in show on an African-American owned radio station, an annual holiday event for the target population, a local anti-stigma campaign which sponsors films about mental illness at *Ebertfest*, a nationally-recognized film fest).

9. Increased Capacity and Quality of Services

Because a SOC serves youth with serious mental health difficulties in the most *effective and efficient way*, avoiding replication, minimizing recidivism, engaging natural supports, improving communication and tracking, and increasing family and community engagement and ownership, the ACCESS Initiative expects to be able to serve *more youth (and their families) in a sustainable and cost-effective way* by using a three-tiered approach to services. Specifically, as

part of our overall annual service count, we expect to serve 320 youth with SED from the targeted population with family-driven, strength-based, culturally competent, individualized Plans of Care, with approximately 80 youth receiving full Wraparound services through our Care Coordinators (12-15 contact hrs per month), 150 youth receiving intense family-driven individualized Family Advocacy services (6-8 contact hrs per month) and another 100 youth with Engagement and Referral services through intake triage. About 300 of these youth will also receive crisis services via SASS. Through increased use of EBPs and better coordination with other child serving systems, we also plan to increase the percentage of youth reaching ISP goals and reduce the percentage involved with the juvenile justice system, expelled from school and placed into foster care. A critical component is tapping into the natural supports, strengths, and healing capabilities of the community, and of the African American community in particular. Thus, the Initiative will expand on a number of successful evidence based and practiced based interventions by training and supporting family members, youth, and community members (e.g., ministers, African American teachers) to become providers of services, trainers, advocates, and Social marketing. At the same time, collaborations with youth serving systems (e.g., school, public health, child welfare) will influence attitudes and practices in those systems. The anti-stigma and Social marketing strategies will also have some positive effect on issues noted by families that affect empowerment, such as internalized oppression and collective silence.

Improvements to service access and quality will begin through the provision of intensive, comprehensive and ongoing training on cultural and linguistic competence and SOC philosophy for governance members, staff, providers of services and supports, and community leaders. Access and quality will be improved through the expansion of the array of evidence based practices, such as Parenting with Love and Limits. EBPs will be modified, when appropriate, to serve the targeted population, based on input from the Evaluation Team, family and youth. Access and quality will also be improved through the expansion of care coordination, use of paraprofessional Family and Youth Advocates in the provision of individualized services and review of outcome measures. Formalizing an inclusive governing board, cross-system procedures and family organization during the cooperative agreement will assure mechanisms for continued leadership development, program guidance and Advocacy from constituent groups.

10. Relationship with Constituent Groups

Since 2002, Project ACCESS membership has included individuals who represent local and state youth-serving agencies and programs (court services, Juvenile Detention Center, DCFS, SASS, school districts, etc.); family groups and organizations (Parents as Partners, etc.); youth from the target population (Peer Ambassadors); representatives of community-based groups (*Why We Can't Wait* African American group of service providers, faith leaders, and educators; ECIRMAC refugee assistance, and the Latino Partnership); local funders (CCMHB) and provider agencies (MHC, Talks Mentoring, Best Interests of Children, etc). Constituents have been consistently involved in ACCESS meetings and subcommittees, visioning, policies and decisions (e.g., creation of Release of Information and Care Coordination process), and reviewing of this application. ACCESS leaders are diverse individuals in regards to race, ethnicity, immigration status, language, religion, sexual orientation, gender, and age, and include substantial representation from the African American community. Appendix 1 contains signed letters of support from some of the parents who have been involved in Project ACCESS and from agencies, child-serving systems, and key leaders and stakeholders in Champaign County.

11. Nonfederal Match and Interagency Collaboration The nonfederal match for this program received from local and state agencies demonstrates the commitment to increasing collaboration and willingness to support this program financially. A Year 1 match (primarily through the Champaign County Mental Health Board) of over $700,000 far exceeds SAMHSA requirements. Other non-Federal sources include IDHS/DMH; DCFS; Illinois State Board of Education; and local fundraising efforts for specific programs; Federal funds will not be used to supplant non-Federal funds dedicated to Project ACCESS. The Executive Director of CCMHB will be the ACCESS Initiative's Co-principal Investigator. Commitments are provided in Appendix 5.

In Year 1, the administrative team will seek additional funding sources, to include developing the system to maximize the availability and use of Medicaid funds under Illinois Rule 132 and through the Frances Nelson federally-qualified health clinic and seeking better integration of revenue streams from state DHS, DCEO, DCFS agencies and local funders for wrap services. Care plans will be coordinated with education, child welfare, and juvenile justice to leverage sustainable funds from those sources. Other potential funders for continued investment include public housing, faith based organizations, the United Way, foundations, local service groups, local businesses and the community itself through fundraising. Participation of funding organization representatives in the ACCESS Initiative since 2002 demonstrates commitment and cooperation to assure successful outcomes.

B2: SERVICE DELIVERY

1. Service Array

Utilizing the strategies described above, the ACCESS Initiative will provide, expand and/or develop the county's array of mental health, optional, and non-mental health services and supports as shown in Table 2, to be integrated into Individual Plans of Care.

Table 2a: Required Mental Health Services to be Integrated into Plans of Care

Diagnosis; Evaluation	Available at: MHC, PSC, Pavilion, Crosspoint Human Services; ACCESS Initiative plans increased access for African American youth with SED.
Cross-system care management	ACCESS Initiative plans SOC contracts/MOUs; for levels 2 & 3; Wraparound and Family Advocacy Models.
Development of ISP	ACCESS Initiative plans for levels 2 & 3; Care Coordinators through Wraparound; Family Advocates through Advocacy model; includes Youth/Family Team.
Community-based Services	Currently providing assessment, counseling, family therapy, consultation, Advocacy, medication management and mentoring through mobile teams in clinics, shelters, homes, schools, churches, JDC. ACCESS Initiative plans expansion through Youth, Family Advocates and School & Community Resource Developers.
Emergency & Crisis Services (24/7)	ACCESS Initiative will integrate with SASS (mobile crisis outreach & intervention, including 90 day intensive mental health services for youth). MHC 24 hr adult crisis line; Pavilion crisis assessment.
Intensive home-based services (24/7)	Intact Family Cases Program (DCFS); Catholic Charities; Best Interest of Children; ACCESS Initiative plans integration into POC.
Intensive day treatment services	CIRCLE Academy (operated by Cunningham Children's Home); Pavilion Behavioral Health Systems. ACCESS Initiative plans integration into POC.

Respite care	MHC Roundhouse temporary housing for youth in crisis; DCFS respite for foster families; Crisis Nursery respite for families who also have younger youth (0-5); Catholic Charities foster care network. Respite recognized as gap; ACCESS Initiative plans to create formal respite services and enhance informal respite networks.
Therapeutic foster care	Lutheran Social Services, Catholic Charities, Cunningham Children's Home. ACCESS Initiative plans integration into POC.
Therapeutic group homes	Cunningham Children's Home. ACCESS Initiative plans integration into POC.
Transitional Service Assistance	Cunningham Children's Home Transition Living Program (TLP), MHC Independent Living (ILO); Schools – Individual Education Plans; ACCESS Initiative plans integration into POC.
Family Advocacy and Peer Support	Family Advocacy Program, Community Advocacy Program, Girls Advocacy Program (PSC); Peer Ambassadors (MHC), Self Help Center; ACCESS Initiative plans to create Youth and Family Organizations, use Advocates as providers, train consumers as advocates.

Table 2b. Optional Services to be Integrated into Plans of Care

Eligibility screenings	ACCESS Initiative plans to locate trained intake workers at partner agencies; Intake Coordinator; Family Advocates
Training in system implementation	ACCESS Initiative plans training in SOC, Wraparound, Cultural & Linguistic Competence, MIS, etc.
Therapeutic recreation	Pavilion; Cunningham Children's Home; Champaign Urbana Special Recreation. ACCESS Initiative plans integration into POC.
Mental health services	Consultation, child therapy, play therapy, family therapy, adolescent group therapy at many partnering agencies; Evidence based and practice based interventions available. ACCESS Initiative plans integration into POC.
Customized suicide prevention and intervention	County has addressed suicide prevention and intervention since 2004. Efforts have included community study session with representatives from SASS, MHC, and PSC; work with coroner, media, and Illinois Suicide Prevention Coalition; education of providers in community agencies. ACCESS Initiative will build on these efforts and work on expanding youth resiliency and protective factors.

Table 2c. Non-Mental Health Services to be Integrated into Plans of Care

Educational services for youth with special needs	Cunningham; Pavilion Foundation School; R.E.A.D.Y. program (Illinois Safe Schools Act) for grades 6-12; Schools- Individual Education Plan (IEP). ACCESS Initiative plans integration into POC.
Primary Health Services	Carle/Provena health systems; Frances Nelson Community Health Center; CUPHD; Urbana School Clinic; Child Dental Access Program. ACCESS Initiative plans integration into POC.
Substance abuse prevention and treatment	Pavilion (inpatient alcohol & drug treatment, stabilization and evaluation, medical detoxification, day/evening outpatient alcohol and drug treatment, continuing care group for families with chemically dependent adolescents) Operation Snowball (youth-led prevention activities); ACCESS Initiative plans

	integration into POC.
Out-of-home acute inpatient & residential	Cunningham Children's Home; Pavilion; Lincoln's Challenge (military-modeled life skills program); emphasize least restrictive settings. ACCESS Initiative plans integration into POC.
Vocational counseling, rehab, transition (IDEA)	Illinois Job Corps (residential GED and vocational); Workforce Investment Board Youth Council provides workforce prep/job placement through county schools/summer programs; Cunningham Children's Home vocational services. ACCESS Initiative plans integration into POC.
Protection and Advocacy	CASA (Court Appointed Special Advocates) – Guardian *ad litem* for county; Children and Family Research Center; ACCESS Initiative plans addition of Family Advocates/Care Coordinators.
Collaboration with Primary care and MR/DD	ACCESS Initiative plans that physicians, pediatricians, public health nurses, dentists, CCRPC be oriented to SOC, invited to be on Youth-Family Teams, and involved in referral/Wraparound options (e.g., provided with forms and info).
Legal Services	Public Defenders Office; Land of Lincoln Legal Assistance; private attorneys. ACCESS Initiative plans integration into POC.
Basic Needs	Eastern Illinois Foodbank and local food pantries; Department of Healthcare and Human Services local field office; Champaign County Regional Planning Commission (LIHEAP/rent assistance); township offices; emergency shelters; Roundhouse. ACCESS Initiative plans integration into POC.
Education/ Literacy Services	Reading Group; School tutoring programs; GED at Parkland College and Urbana Adult Education; financial literacy classes taught by CCRPC and Land of Lincoln Legal Assistance. ACCESS Initiative plans integration into POC.

***a. Development of Evidence-Based Practices and Practice-Based Interventions* -** The Initiative will expand the use of current successful EBPs, including Dialectical Behavior Therapy, Family Group Decision-making, trauma focused cognitive behavioral therapy, cognitive behavioral groups, Wraparound, and the Advocacy Model. Based on analysis of needs and family input, the Initiative will add new EBPs (Parenting with Love and Limits, Families and Schools Together, Mobile Urgent Treatment Team, and Parent Management Training – Oregon Model) and expand use of practice based models such as Effective Black Parenting, which have had significant positive outcomes with families in the local community.
***b. Development of Culturally Competent Providers* -** To increase the cultural and linguistic competence of local providers, the ACCESS Initiative will provide mandatory CLC Orientations for all providers working with youth, CLC Leadership training for all agency leaders (e.g., based on a 3-day workshop offered by UIUC for Mental Health agency leaders in 2007), and create, with parent and youth input, a CLC Provider list of local providers who have high consumer ratings for CLC services (e.g., for youth with sexual orientation concerns, etc.). This approach is founded on research that shows that for significant change to be implemented in organizations (e.g., policy changes, staff accountability), front-line providers, organizational leadership, and consumers must "buy into" and be meaningfully involved in the change effort. The ACCESS Initiative will significantly expand community service locations through the work of Family/ Youth Advocates, School and Community Resource Developers), as well as earmarking flexible funds for supportive non-mental health services based in the community.

c. Data/Fiscal Transformation - Development of shared MIS data from centralized intake and care management will provide more information that will reduce duplication of services and enable the SOC to redirect resources to increase capacity for services based on needs identified by youth/families. Funding for these activities will be made possible through a combination of leveraged resources (private insurers, fees, other state agencies such as Department of Public Health and non-profit agency fundraising efforts) and a restructuring of the fiscal infrastructure of the county's service system. Currently, the Mental Health Board (CCMHB) provides much of the funding for non-state-funded mental health, substance abuse, and support services in Champaign County through an annual competitive RFP process. Working with the ACCESS Initiative over the course of the cooperative agreement, the CCMHB plans to create a centralized pool of money which will be used to develop and implement service components for youth in which service dollars "follow the child and family." Fiscal restructuring will free up money for sustainability post-SAMHSA investment, since services and supports delivered through a SOC significantly increase cost effectiveness through improved access, quality, engagement and retention; faster and longer-term outcomes; and improved participation.

2. Delivery of Clinical Interventions

a. Eligibility, Referral, and Enrollment - Youth aged 10-17 with mental health needs that place them at risk for involvement with, or re-entry into, the juvenile justice system, are eligible for services. Using Federal SED guidelines, youth must have an appropriate disorder diagnosable under *DSM-IV* and a disability impairing their functioning in their family, school, or community that must have been present for one year or be expected to last for at least one year. Due to their disproportionate representation within the justice system, African American youth will be considered a priority population.

Referrals to the program will come through schools, the community, juvenile justice, public health, primary mental health providers, faith-based services, and the Screening Assessment and Support Services (SASS) crisis line. An agency-based intake worker or trained community-based screener (Family Advocate) will respond to referrals within 24 hrs, or 90 minutes in crisis situations (SASS), to set up an in-person eligibility intake using the Childhood Severity of Psychiatric Illness Version 2.0 (CSPI-2). Through a centralized administrative form entered into the MIS and based upon demonstrated need as decided by the youth, family, and intake worker, families will be enrolled into one of three levels of service intensity:

- *Level 1: Family Engagement*: engagement and early intervention (e.g., linkages to needed services) offered by intake screeners. Intake follow-up will be available for at least 90 days.
- *Level 2: Family Advocacy and Mentoring:* intensive, strength-based, family-driven individualized care coordinated by a trained Family Advocate using evidence based Advocacy Model (Sullivan *et al.*) and modified for local families (Hunt).
- *Level 3: Care Coordination:* full Wraparound services and individualized Plan of Care facilitated by Care Coordinators with fidelity to the National Wraparound Initiative. Levels 2 and 3 services use the Child Assessment of Needs and Strengths (CANS, Lyons, 1999).

b. Diagnosis and Treatment Planning - Multi-axial DSM-IV diagnosis will be obtained for all Level 3 and most Level 2 youth by clinicians at the Mental Health Center (MHC), the University of Illinois Psychological Services Center (PSC), the Pavilion, or Crosspoint Human Services. Diagnoses and treatment planning will be conducted within the context of individualized Plans of Care, with consideration to the youth's and family's strengths, needs, values, and unique

ethnic and cultural context. Clinicians at these sites are trained and supervised in the assessment and utilization of DSM-IV diagnostic criteria (e.g., using structural clinical interviews) and will receive additional training in the appropriate application of DSM-IV diagnostic categories to diverse populations (e.g., race, ethnicity, sexual orientation, immigration and acculturation status, language, gender, etc.). Emphasis will be on community-based services, and diagnostic services, treatment planning, needs and strengths assessments, mental health and other services are currently being offered by a number of local agencies through the schools, the JDC, shelters, community centers, local clinics, faith-based organizations, libraries, and other locations preferred by families (e.g., their homes); these will be further developed under the ACCESS Initiative. Table 3 lists evidence-based and practice-based interventions which are expected to best meet the needs of the targeted population because they have been effective with children, adolescents, and family members (including those who are African American) in decreasing depression, anxiety, aggression, trauma symptoms (prevalent in children with system involvement), recidivism, and restrictive living situations, while improving life satisfaction, safety, cost effectiveness, functioning, empowerment and family cohesion. Continuous quality improvement processes will identify and address adaptations needed locally based on youth/family input and outcomes.

Table 3a: Current EBPs and PB Interventions (to be expanded locally)

Title and Representative Research	***Population & Outcome Evidence*** (all outcomes include diverse youth & families*)*
Wraparound -VanDenBerg & Grealish, 1996 -Yoe1, Santarcangelo, Atkins, & Burchard, 1996 -SAMHSA Promising Practices series	**SED youth & their families**: reduced restrictiveness of living situations & cost of care; improvement in Social, school, and community functioning; high consumer satisfaction & sense of empowerment
Advocacy Model (Family Advocacy) -Davidson & Redner, 1988 -Sullivan et al, 1994 -Sullivan & Bybee, 1999	**JJ adolescents, battered women & their children, African American & low income families** (with local modifications by Hunt - *e.g.,* use of cultural brokers): reduced depression; increased self-efficacy, access to services, self-Advocacy, life satisfaction, safety
Dialectical Behavior Therapy -Katz, Cox, Gunasekara, & Miller, 2004 -Linehan, Cochran, & Kehrer, 2001 -Trupin, Stewart, Beach, & Boesky, 2002	**Suicidal (inpatient & outpatient), incarcerated & BPD adolescents**: reduced depression, suicidality, personality disorder symptoms, & punitive measures by JJ staff
Trauma focused CBT -Butler, Chapman, Forman & Beck, 2006 -Cohen, Mannarino, Berliner, & -Deblinger, 2000 -March, Amaya-Jackson, Murray, & Schulte, 1998	**PTSD adults, children & adolescents**: reduced PTSD, anger, anxiety, depression, & increased internal locus of control (empowerment)
CBT groups for adolescents -Clarke et al, 1999 -Vickers, 2002 -Wignall, 2006	**SED adolescents, including co-morbidity**: reduced depression, Social skill deficits, externalizing behaviors
Parenting Wisely	**Pregnant & parenting teens, parents of adolescents**

-Kacir & Gordon, 1997 -Lagges & Gordon, 1997 -Segal et al, 2003	**with SED**: increased parenting knowledge, satisfaction & positive parenting practices; decreased problem behaviors
Effective Black Parenting Program (*Evidence & Practice-based locally*) -Meyers et al, 1992 -Alvy, 1994 - CA Evidence Based Clearinghouse	**African American parents of SED youth, court referred, teen parents:** increased positive parenting practices, family relationships, youth competencies; decreased SED, problem behaviors, delinquency, parent dysfunction, recidivism, foster-placements
Family Group Decision-Making (*Growing Evidence*) -Burford & Hudson, 2001 -Merkel-Holguin, 2003 -Pennel & Burford, 2000	**Families of at risk youth & system involved**: increased family empowerment, child safety (reduced violence & re-abuse), stability in out-of-home placements & kinship placements, family supports, & family functioning

Table 3b: New EBPs (to be considered with input from youth/families)

Families And Schools Together -Selected OJJDP best practice model -Penry, 1996 -McDonald et al, 1997	**Families & schools with SED youth**: reduced substance abuse, aggression & violence; improved positive scholastic behaviors (e.g., attention span), resiliency factors, & community variables (parent networks, parent-school relationships)
Parent Management Training OM -Listed as EBP in SAMHSA/ NIMH/NASMHPD Statewide Transformation Conference, 2006 -Dumas, 1989 -Kazdin, 1988	**Youth with oppositional, aggressive & antisocial behavior**: decreased antisocial behavior; increased pro-Social behavior, parental adjustment & functioning, marital satisfaction, & sibling behavior
Parenting with Love and Limits -Sells, Smith, Rodman & Reynolds, 2006 -Sells, 2001 -Sells, 1998	**Families with JJ Youth**: reduced recidivism, detention, JJ costs, substance use, re-offenses, aggression, ADHD, depression, externalizing; increased parent involvement
Mobile Unit Treatment Team (*Growing Evidence*) -Listed in AHRQ Innovations Exchange -Pires, 2002 -Wraparound Milwaukee	**SED Youth in crisis**: reduced use, length of stay & costs (by 50%) of inpatient psychiatric facilities; high satisfaction from caregivers, police & schools

3. Care Coordination/Individual Service Plans

a. Care Coordination and Family Advocacy **–** Each of the 10 Care Coordinators (CCs) will serve 8 families annually with 12-15 hrs of contact/month/family, for an annual total of 80 youth, using full Wraparound care coordination (Level 3). The 10 Family Advocates (FAs) each will serve 12 families annually with 6-8 hrs of contact/month/family for an annual total of 120 youth, using intensive individualized Family Advocacy (Level 2). With some overlap of youth between years, approximately 150-200 unduplicated youth with SED will be served annually by the time care coordination is fully implemented in Year 2. Another 100 at-risk youths will receive Level 1 Engagement services for a grand total of 300 youths per year receiving all types of services,

including prevention. The CC/FAs will be trained and supervised centrally, but housed in a number of community agencies, in order to increase access for families. Special attention will be given to the recruitment, hiring, and workforce development of CC/FAs with the goal of maximally reflecting the target population. Care Coordinators will ensure that services are provided with fidelity to the Wraparound process, will assure meaningful participation on the Youth/Family (YF) Team of youth, family, and all other members. Care Coordinators and FAs will also advocate for the youth with the courts, providing information on the family's strengths and needs, and creating a Safety Plan within the least restrictive setting. To ensure fidelity to the Wraparound and Advocacy models, training, certification, coordination with the evaluation team, use of the Wraparound Fidelity Index (WFI) and Advocacy fidelity measures, and development of the Quality User Assurance and Grievance Implementation (QUAGI) procedures will be in place. All CC/FAs will attend mandatory orientation and ongoing training on Wraparound or Advocacy philosophy and practices in addition to obtaining required Wraparound Certification (40 hrs of training) or Advocacy Certification (20 hrs of training) within six months of hire and attending frequent training in cultural and linguistically competent provision of services, as well as other relevant information (e.g., suicidality, mandatory reporting). The Care Coordination Supervisor will ensure that they have supervision, support and regular in-services, as well as the tools (e.g., cell phones, pagers, computers), to be successful.

b. Individualized Service Plans (Plans of Care) - In partnership with the youth and family, Care Coordinators will assemble the Youth and Family Team (which may include primary care physician and/or developmental disability, school or other case managers that already have specialized service plans with youth/family) within 2 weeks of family enrollment. Each youth/family will have a single CC/FA responsible for coordinating care through Wraparound or Advocacy models, and the agency where the CC/FA resides will be considered the lead agency for care coordination. A Care Coordination Supervisor will be responsible for training, direction and coordination of all CC/FAs to assure consistency of procedures and practices. For both CCs and FAs, the initial Plan of Care (POC) will be completed within 30 days of enrollment (or transfer to new Care Coordinator); subsequent POCs will be completed every 60 days. For Wraparound, POC meetings will include all team members, including youth and primary caregiver, who will have ample notification of the meeting times. All POCs will include four phases of service delivery (Engagement, Assessment, Implementation and Follow-up), will be guided by an overall *Family-Youth Goal Statement* (written in the family's language) and will include, but not be limited to, the following parts:

1. *Family-Youth Strengths and Resources*: regularly updated list of youth and family strengths with attention to functionality within POC; includes community and natural supports; description of POC integration with appropriate services, including those available from youth/family and under IDEA, IEPs and Transition Services;

2. *Family-Youth Narrative*: based on family's description of family composition (including extended family and supports); family background (culture, traditions, routines, values); chronology of events (treatment history, risk history, youth placements, etc.); and youth behavioral history (current and past behavior concerns, issues related to school, legal and other systems, previously successful and unsuccessful interventions);

3. *Family-Youth Needs, Objectives, and Strategies*: list of family/youth needs by domain (including mental health, legal, educational/vocational, safety, and others as identified by family); a DSM-IV multi-axis diagnosis; and specific *Target Objectives* and *Strategies* (or

methodologies) for accomplishing objectives, with target dates. Strategies should include resources most appropriate to the unique family strengths, needs, values, and culture of family.

4. *Family-Youth Crisis and Safety Plan*: family's definition of crisis; strategies based on caregiver and youth strengths, capacities, previous solutions, needs, and relevant data (e.g., medical information, DSM-IV diagnosis); customized intervention plan for youth at risk for suicide or other harmful behavior (e.g., violence risk);

5. *Family-Youth Permanency Plan*: provisions for coordination with Court Services, DCFS and other mandated parties with regard to guardianship issues, as needed; emphasis to be placed on family preservation efforts and community-based services to support strengths and address areas of concern.

c. Quality Assurance and Grievance Process – Review of Individual Service Plans will occur quarterly to monitor and update service provision as needed and record progress toward goals. The Quality User Assurance and Grievance Implementation process (QUAGI) will help ensure that services and supports delivered under the ACCESS Initiative will maximally meet the needs of youth and families, as well as the goals of the Initiative (e.g., increasing community capacity, ensuring fidelity and sustainability). The QUAGI will include a process which incorporates ongoing findings from the Evaluation team regarding consumer satisfaction, family and youth outcomes, fidelity to the process, and other relevant quality measures, as well as a procedure which will follow guidelines established by the Department of Health & Family Services/HFS 94 – Patient Rights and Resolution of Patient Grievances. Specific policies for complaint filing, grievance procedures, and resolution will be established in the planning year with input from families and youth, but will include (a) process for "informally" addressing conflicts; (b) procedure and timeframe for filing complaint (e.g., within 60 days of incident) and procedures and timeframe for responding to complaint (e.g., within 14 days or 48 hrs if critical); (c) procedure and timeline for formal grievances, with process for acknowledging, investigating, reviewing (e.g., grievance committee and grievance hearing), and notifying the grievant of decision in timely manner and (d) appropriate, accessible information (e.g., Complaint & Grievance Handbook), and forms for all QUAGI procedures.

4. Family-Driven Care

Many family partnerships are already in place in the county and driving the vision and development of the proposed initiative. These will be strengthened by the involvement of family members in provision of services (e.g., Advocacy, training, engagement) and on the Governing Body. The creation of a formal Family Organization will be fully supported by the ACCESS Initiative, and will include family members from many sources, including former consumers of the Initiative and members of the following groups, which are majority African American:

- *Parents As Partners* – a Project ACCESS sponsored movement recognizing the expertise of parents with respect to their children, families, and communities. *Parents As Partners* connects parents with the child-serving professional community.
- *Parent Advisory Council* – a joint effort of Project ACCESS, the C&A LAN, and SASS that focuses upon advising service providers and system partners.
- *Parent to Parent* – a joint effort between Project ACCESS partners, offering support and education to parents on a wide variety of issues, from parenting and problem-solving to civic engagement. Parent to Parent will be used to empower participants in the family organization.
- *Walk the Talk Support and Education Group* – bimonthly group involving parents who have "graduated" from Advocacy, Mentoring, and Effective Black Parenting services provided by

the Psychological Services Center.

The ACCESS Initiative will work with the *Illinois Federation of Families (IFF)*, a CMHS-funded affiliate of the Federation of Families for Children's Mental Health. This statewide not-for-profit organization provides support, education, training and Advocacy for families with children who have emotional, behavioral, and mental health needs. The ACCESS Initiative is fully committed to the development of a formal Family Organization and will provide partial funding for its creation and sustainability through Mental Health Board money. Support and consultation has also been pledged by the local chapter of the *National Alliance on Mental Illness* (NAMI), and financial support will be additionally sought from other sources

Advocacy, mentoring, and psycho-education services (e.g., Effective Black Parenting, Family Advocacy and Community Advocacy Programs, Anger Management for JJ Youth) currently being offered in the county to families of color and families living in poverty, have a long-standing history of providing incentives to participating youth and families, which have been funded, in the past, by both the Mental Health Board and Court Services. Family and youth incentives have included family-style meals at every meeting, free program materials, “perfect attendance” incentives (e.g., gift cards), transportation reimbursement (e.g., bus tokens), free child care, and “graduation” celebrations (e.g., banquets with catered meal, keynote speaker, free family portraits, and graduation certificates),with the goal of supporting the continued participation of families and youth in the implementation, evaluation and sustainability of the SOC. Similar stipends and incentives (e.g., meals, transportation reimbursement, child care) will be provided by the Initiative to members of both the Family Organization and the Youth Advisory Board in order to support meaningful and sustained involvement by family and youth.

5. Youth Guided Care

Youth participation in the project has been guided by the Peer Ambassadors. Based at the MHC, the Ambassadors are nationally recognized youth leaders from the target population. The Ambassadors have collected data from youth involved with the juvenile justice system that has been instrumental in shaping the efforts of SOC development in Champaign County and are active participants in Project ACCESS and the JDC Pilot. They also host recreational activities for youth, act as peer counselors and role models, and host focus groups with youth who have been affected by the justice system. The Peer Ambassadors presented their findings at the 2007 Federation of Families for Children's Mental Health conference and have been invited to participate on the National Youth Advisory Board being established by the Systems of Care national evaluation team.

The Peer Ambassadors will be active participants in hiring a Youth Coordinator to create a Youth Advisory Board (YAB), which will actively participate in the governance of the ACCESS Initiative. The YAB, in coordination with other youth leadership groups, will host regular community forums and an annual youth summit for the target population, and make outreach efforts in partnership with Operation Snowball, a very successful youth-led substance abuse prevention program The Peer Ambassador program manual will include materials necessary for the replication of the program in other communities and will be made available to the technical assistance partnership and other CMHI sites. With training and support from the Technical Assistance Coordinator and development of an annual work plan and budget, youth from the YAB will be involved in service provision (e.g., engagement, Advocacy), evaluation, and sustainability efforts (e.g., plans to establish a community-funded Teen Center in Champaign County).

6. Cultural and Linguistic Competence and Responsiveness
a. Standards - The ACCESS Initiative will meet federal standards regarding cultural and linguistic competence outlined in the National Standards on Culturally Linguistically Appropriate Services (CLAS), the Center for Mental Health Services (CMHS) and follow best practice recommendations found in sources such as the National Center for Cultural Competence and *Mental Health: Culture, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General*. All ACCESS Initiative partners will be in compliance with Title VI of the Civil Rights Act and are committed to services and employment practices that do not discriminate on the basis of race, ethnicity, culture, color, national origin, language, age, sex, gender, sexual orientation, or religion.
b. Plan of Care/Diverse Participation **-** Individualized service plans will be built around the preferred language, values, customs, natural healing practices, religious and spiritual beliefs, strengths, and natural support networks of each family. Because African American youth and families are over-represented in our justice system, the full participation of professionals, parents, youth and community members from the African American community will continue to be sought for every aspect of the Initiative. These include strategies for participation in workforce development, Advocacy and engagement, Youth/Family Teams, project governance (and preparation of this application), and staff positions that recognize real-life experience as well as formal degrees. In addition, care has been taken that other under-represented groups have helped shaped the Initiative (e.g., LGBTQ community, people with disabilities, Latino community).
c. Management and Service Provision -The leadership of Project ACCESS is comprised of individuals who are diverse in regard to race, ethnicity, immigration status, cultural background, age, gender, sexual orientation, religion, and consumer status. The roles of Family Advocates and Care Coordinators are expected to reflect the demographic representation of youth and families (as is the case right now with the Family Advocates in the current service array). The Initiative will build on the current utilization of cultural brokers and natural healers by involving these individuals in consultation and service provision roles, and supporting their participation through training and incentives. In addition, the Initiative plans to significantly increase the cultural and linguistic competence of providers and leaders within the larger service array through a combination of training events, early and often, specifically in hiring practices, workplace environment and provisions for feedback. These strategies are expected to bring about meaningful change in organizational structures and climates in terms of cultural competence, and contribute to sustainability.
d. Increased Service Access and Quality - Service and access disparities disproportionately affecting African American youth and families will be addressed through increasing the diversity of available providers or use of cultural coaches who offer culturally competent services showing evidence of success with the target population; the increased capacity of the community to support targeted youth, including schools, community based services and natural supports and healers; and the decrease of stigma and mistrust associated with mental health services (especially in the target population) through Social marketing and engagement of consumers by families and youth. The implementation of family-driven and youth guided individualized service plans, which will increase family engagement and family voice, and a philosophical and practical shift in how services are delivered to target youth, will also increase capacity, efficiency, cost effectiveness, efficacy, and satisfaction with services while decreasing recidivism, duplication, and services that do not meet the needs of the population. The development of the Quality Users Assurance and Grievance Implementation process (QUAGI) will also greatly

improve system fidelity and accountability, and ACCESS Initiative policies/procedures, will help ensure that youth and family service plans are specific to family characteristics.

The Cultural and Linguistic Competency Coordinator will chair a workgroup of families, youth and providers (and consultants as needed) that will develop a specialized cultural competence plan with a set of standards (following SAMHSA guidelines) that meet the specific cultural and linguistic needs of Champaign County's minority populations and comply with Title VI of the Civil Rights Act, CLAS, and all other requirements; and a set of steps, providing direction and guidance to establish and implement policies, practices, procedures, evaluation, and structures that will comply with these standards. Cultural and linguistic competence will be infused through all training, governance, administration, marketing and service provision activities, and will be the focus of specific ongoing trainings required for project staff and partners.

B3: SUSTAINABILITY/LINKAGES WITH STATEWIDE TRANSFORMATION EFFORTS AND OTHER RELEVANT FEDERALLY-FUNDED PROGRAMS

a. Coordination of Linkages/Partnerships - IDHS/DMH will use lessons learned through System of Care – Chicago and McHenry County Family CARE to help ensure the success of the ACCESS Initiative and form a similar mentoring relationship with Vermilion County, which could serve as a model for replicating SOC structures throughout the state.

As part of the statewide mental health transformation activities, IDHS/DMH is in the process of transitioning to a fee-for-service payment system, a more client-centered model. Because a fee-for-service system provides reimbursement on the basis of individual services provided, an individual client's choice impacts providers more directly than grant-based funding. This change will introduce greater efficiency, accountability, and provider sustainability into the system, based on equitable reimbursement for quality services provided in response to demonstrated need.

IDHS/DMH has incorporated SOC principles into its contracting requirements. State-funded IDHS/DMH provider agencies must demonstrate that families have a voice in local program development and policy and must deliver the majority of services in natural (non-office) settings. IDHS/DMH has also hired parent consumers to work with Tanya Anderson, M.D., with the Child and Adolescent Service System Central Office team. These changes have had a positive effect on the statewide delivery system for mental health services. At the time of the publication of the President's New Freedom Commission (NFC) on Mental Health report in July 2003, IDHS/DMH was already envisioning a Comprehensive State Mental Health Plan for Illinois, fully aligned with the NFC. IDHS/DMH has made significant steps in working with other state departments to coordinate activities including medication purchasing, medical decision-making, clinical information system sharing, quality management, professional workforce development. IDHS/DMH has entered into initiatives with other IDHS divisions, including grant collaborations and policy and service plan development. IDHS/DMH has trained community mental health partners from System of Care – Chicago in billing codes and strategies to support staffing beyond the SAMHSA grant funding investment, as is the expectation for the ACCESS Initiative.

Staff from the IDHS Office of Grants Administration has a strong historical record of presenting data from evaluations of successful federally-funded programs to the legislature and winning continuation and replication funding when new funding is available. This office's Bureau of Evaluation, Knowledge Dissemination, and Technology Transfer publishes an annual report of evaluation findings from all federal projects which is used to support sustainability efforts. Findings and Lessons Learned from Family CARE and System of Care – Chicago were

published in the February 2007 report; annual findings from the ACCESS Initiative will be included if it is funded.

b. Sustainability - Sustainability of the ACCESS Initiative will be predicated on a cooperative arrangement between IDHS/DMH and CCMHB. It is the policy of CCMHB to allocate new dollars and redirect existing resources to sustain Federally-funded projects that have demonstrated efficacy and achieved positive outcomes for the community. Significant local resources already have been dedicated to SOC development: sustainability of the SAMHSA award is clearly consistent with this mission. As noted above, additional sustainability efforts at the local level will begin in the planning year through the development of alternate funding streams. In particular, the ACCESS Initiative will explore the feasibility of development efforts dedicated to building a broad base of funding streams (including leveraging Social marketing to double as donor cultivation for private contributions) and an endowment to create long-term financial security. A non-categorical funding stream will be essential to ensure a source for flexible funding that "follows the youth" to cover gaps in a silo-based funding environment.

IDHS/DMH annually submits goal and objectives within the Federal Block Grant Action Plan to the Center of Medicare and Medicaid Services. Currently, IDHS/DMH submits these for both Family CARE and System of Care – Chicago. Under the cooperative agreement, IDHS/DMH will do this for the ACCESS Initiative as well. It will also plot the progress of the ACCESS Initiative and maintain a focus on sustainability through future legislative proposals.

Dr. Tanya Anderson (Co-principal Investigator) was instrumental in the development of the protocols and application for a Safe Schools/Healthy Students grant recently awarded to Chicago Public Schools and is part of the core partnership team of that initiative.

Finally, statewide integration efforts will include MOUs with SASS, the children's crisis program; MHJJ (Mental Health Juvenile Justice) program; Individual Care Grants for Mentally Ill Children; Community Action Agency (CCRPC/DCEO), and DCFS connections through the LAN, and influence with other youth-targeted initiatives, including the Illinois Children's Mental Health Partnership (both co-PIs), the Administrative Office of Illinois Courts (through the Head of Court Services, Joe Gordon) and the Association of Community Mental Health Authorities of Illinois (through a number of Project ACCESS Partners).

SECTION C: PROJECT MANAGEMENT AND STAFFING PLAN

1. Capability and Experience of Applicant and Other Participating Organizations

The Illinois Department of Human Services/Division of Mental Health (IDHS/DMH), the mental health authority for the State of Illinois, will be responsible for the overall management of the proposed Cooperative Agreement for the Comprehensive Community Mental Health Services Program for Children and their Families. Under the leadership of Secretary Carol Adams, Ph.D., IDHS has been dedicated to best practices, innovation, and technology transfer and recognizes that significant change in systems, organizational cultures, and practices are best achieved through partnerships. Dr. Adams spearheaded the transformation of IDHS/DMH contracting requirements to reflect SOC values and established the Bureau of Evaluation, Knowledge Dissemination, and Technology Transfer, which publishes and disseminates findings and lessons learned from federal initiatives to staff and provider agencies. Applications for Federal funding are coordinated through state agencies, and a letter of assurance showing support from the Governor's office is included in Appendix 2.

IDHS/DMH has the organizational capability to administer and coordinate Project ACCESS as evidence by past partnerships with SAMHSA, including two CMHI sites. These projects include:

- **System of Care – Chicago**: a joint project between IDHS/DMH and the Chicago Public Schools to implement a SOC, bringing a wide range of partners together to meet the needs of children with SED. This project is still under grant funding. Findings from this project have been published and disseminated throughout the state.
- **Family CARE**: IDHS/DMH, in partnership with the McHenry County Mental Health Board, received funding from SAMHSA in 2005 to implement Family CARE a SOC (Child/Adolescent Recovery Experience). Lessons learned from Family CARE have been used in the development of Project ACCESS and the current proposal. For example, the School and Community Resource Developers are based upon McHenry's School Sector Coordinators, Project ACCESS governance structures have been planned to avoid difficulties experienced in McHenry, and the incorporation of SASS services into Project ACCESS will be based upon McHenry's successful SASS integration.
- **State Data Infrastructure Grant**: A three-year grant awarded to IDHS/DMH by SAMHSA to assist in developing and updating the infrastructure to collect and report on a set of performance and outcome measures developed in collaboration with SAMHSA and the 49 States and 7 territories that were also awarded this grant. This project concluded in September 2004.
- **Sixteen-State Pilot Indicator Study**: A three-year grant awarded to IDHS/DMH by SAMHSA that was the precursor to the State Data Infrastructure Grant. This study was a collaboration (with SAMHSA and 15 States) to identify a set of outcome and performance measures that could be used to provide information on the quality of mental health services provided by the publicly funded mental health system.

In addition to the initiatives above, IDHS/DMH is currently spearheading interagency coordination efforts to address the need to break out of the funding and policy silos impeding the delivery of effective and appropriate services to children in Illinois.

The Champaign County Mental Health Board (CCMHB) was established in 1972 by local referendum with a statutory responsibility over community mental health services, “including services for the developmentally disabled and for the substance abuser, for residents of Champaign County.” CCMHB's mission is to promote a local system of services for the prevention and treatment of mental or emotional, developmental, and substance abuse disorders, including outreach and services tailored to the needs of underserved populations. It is the primary local funding source for these services. The CCMHB director will serve as the ACCESS Initiative Co-principal Investigator. Many ACCESS Initiative partners have a long, deeply rooted history in the community and are well-connected to the target population. The Champaign-Urbana Area Project was founded to advocate for public housing residents and focuses on delinquency prevention through grassroots community empowerment. Best Interest of Children grew from a grassroots movement concerned with the disproportionate rate of African American children in substitute care. The Local Area Network partnership upon which the ACCESS Initiative will build its Wraparound services is representative of all four child-serving state agencies and current Project ACCESS partners. Peer Ambassadors are currently 100% African American youth. The Champaign County Regional Planning Commission’s Social Services Division is the local Community Action Agency and has served low-income, minority and at-risk

families for over 20 years.

2. Staff Positions: Roles, Qualifications, and Experience
Table 4 below summarizes all positions and their roles for the ACCESS Initiative. Qualifications for all positions are noted, and key personnel qualifications are expanded to include their demonstrated experience in systems development and in serving at-risk youth, particularly African American youth with SED.

Table 4: ACCESS Initiative Staffing

Position Title/Role	Name/Qualifications	FTE
Co-Principal Investigator Fiscal and administrative oversight of the cooperative agreement	**Tanya Anderson, M.D**.: Illinois' Deputy Clinical Director of IDHS/DMH Children & Adolescent Services; tenured faculty at the University of IL at Chicago, School of Medicine, Dept. of Psychiatry; published on culturally competent mental health assessment and treatment and healthcare disparities; spearheads IDHS/DMH's child and adolescent transformation efforts; is co-principal investigator of both IL System of Care efforts – Chicago and Family CARE; participant in Georgetown University's Transformation Facilitation Fellowship **Peter Tracy, M.A**.: Executive Director of Champaign Co. Mental Health Board; former president of the Association of Community Mental Health Authorities of Illinois; former deputy chief-of-staff of the Illinois DCFS; primary author of the original Illinois Child and Adolescent Service System Program (CASSP) grant in 1985; children's mental health experience in direct service, inpatient psychiatric, rule making, policy development, contracts and grants, and program administration and management.	0.25
Project Director Leadership in all aspects of development and administration of SOC; ex officio member of governing board	**Darlene Kloeppel, M.S.W., M.S., M.C.P**.: Social Services Director for Champaign County Community Action Agency, supervising 30+ multicultural, multidisciplinary staff; program development experience in health care, education, social services; management consultant for strategic planning efforts of regional scope in both health care and juvenile justice arenas; significant training/experience in organizational change management; adoptive parent of four at-risk youth; experience with Federal grant management	1.0
Care Coordination Supervisor Manages all aspects of Wraparound services	**Juli Kartel, M.A., M.S.Ed., LCPC**: Director of Youth and Family Services at Mental Health Center; clinical experience with African American youth in mental health, substance abuse, juvenile justice, school-based services, homeless services; knowledge of clinical best practices; supervision and Wraparound experience	1.0
Technical Assistance Coordinator	**Karen Simms, M.A.M.F.T**.: Community Connections Supervisor at the Mental Health Center; SAMHA SOC training	1.0

Orientation, training of staff/partners of SOC	participant; experience with African American youth, natural support systems, outcome measurement; clinical, teaching and administrative experience	
Cultural Competence/ Linguistics Coordinator Assures cultural competence in all aspects of the SOC	**Patricia Avery:** Director of C-U Area Project, African American grassroots community organizing group; former county board chair; member of Strong Roots/Strong Branches	1.0
Communication/Social Marketing Coordinator Formal/informal outreach/ internal communications; national media liaison	To be selected; B.S., public relations/writing skills; experience with diverse audiences	1.0
Intake Coordinator Screen and triage youth for level of service	**Kimberly Seward, M.S., M.S.W**.: Supervisor of Screening, Assessment, Support Services (SASS) at Crosspoint Human Services, which is local intake point for all Medicaid-funded crisis mental health services for children/youth; clinical assessment , supervisory, training and program management experience	1.0
Intake Data Coordinator Tracking, reporting and outcome measurement; scheduling for intake/care coordination	**Stuart Broz, M.A., J.D**.: Project ACCESS Program Administrator at Champaign-Urbana Area Project; experience with multi-agency forms, database and website development and research/report writing; advocate for youth in child welfare, special education and juvenile justice systems	1.0
Youth Coordinator Coordinate Youth Advisory Board activities; governing board member	To be selected; Formerly at-risk youth; high school graduate; at least 21	.75
Lead Family Contact Oversight/supervision of Family Organization and Family Advocates; governing board member	To be selected; Parent of former at-risk youth; high school graduate	1.0
Care Coordinator Facilitate individual wrap plans and follow-up for level 3 intervention	**Jonté Rollins, B.S**.: Delinquency Prevention Specialist at Champaign-Urbana Area Project; experience with disproportionate number of African American youth at detention center and in foster care; service coordination/reporting for Project ACCESS; community networking experience; Others to be selected, B.S. degree	10.0
Family Advocate Facilitate individual plans for level 2 intervention; family mentor/advocate	**Regina Crider, A.A**.: Associate Minister; Family Advocate and Effective Black Parenting Facilitator at Psychological Services Center; experience with coordinating youth Wraparound services, coaching and locating natural supports with families	10.0

	Others to be selected; Parents who have had children involved in the mental health or juvenile justice systems	
State/Local Liaison Liaison between IDHS/ Champaign County; facilitate sustainability and state SOC replication	To be selected; B.S., budget/systems experience	1.0
School/Community Resource Developer Liaison between schools, agencies, the family organization, and the community supports to build resources for care	To be selected; high school graduate, ties to target populations	5.0
Governing Board Member	To be selected based on representation	1.5
Prevention/Treatment Service Provider	To be selected based on individual wrap plan	N/A
Evaluation Co-Directors Administrative and fiscal oversight of local and SAMHSA national evaluation efforts	**Nicole Allen, Ph.D**.: Assistant Professor of Community Psychology at the University of IL at Urbana-Champaign; experience conducting community-based evaluations with a focus on human service delivery reform and committed to increasing the accessibility of evaluation tools to communities attempting such reform; co-authored a manual for community members on how to evaluate the coordinated community response to domestic violence (Allen & Hagen, 2003); managed multi-year statewide Federally-funded study of system response to family violence; familiar with GPRA requirements **Mark Aber, Ph.D**.; Associate Professor of Psychology at the University of IL at Urbana-Champaign; over fifteen years collaboration with grass-roots groups to do community-based action research in Champaign County on poverty/racism issues	0.44
Evaluation Coordinator Train and supervise research staff; manage data collection/analysis	To be selected; Ph.D.	1.0
Evaluation Research Assistant Implement data collection/analysis	To be selected; M.S., doctoral graduate students	.5
Community Interviewer Interviews/data collection	To be selected; Community member	.5

3. Staff Experience with Target Population

All named staff persons above have extensive experience working with youth with SED, and in particular, African American youth and youth involved with/at risk of involvement with the juvenile justice system. Many are working with this population currently through the local detention center Pilot. Experience with the target population will be a primary hiring consideration, and fifty percent of the staff currently identified for key positions is African American, including one of the Co-Principal Investigators. Efforts to have a diverse staff with regard to race, ethnicity, gender, sexual orientation, age, disability and other population characteristics will be a hiring factor. Family Advocates, Family Organization, Youth Advisory Board, Governing Board members and others will be drawn from the target population to assure cultural competence, access and voice in decision-making. As the target population is predominantly English speaking, interpreters will be used on an as-needed basis.

4. Available Facilities, Equipment, and Resources

Partnering agencies/community groups have offered resources for meetings, interviews, treatment, training, offices, etc. All facilities operated by the Mental Health Center (MHC) and Prairie Center Health Systems (PCHS) will be available. The Community Service Center of Northern Champaign County in Rantoul will provide satellite space for ACCESS Initiative partners. Space will also be available for use at public schools, the READY alternative school sites, and the Juvenile Detention Center, and the Champaign County Regional Planning Commission. MHC is JCAHO accredited, operating with some of the highest and most stringent life safety, ADA compliance, and privacy regulations and oversight. MHC sites are certified under Rule 132, Medicaid Community Mental Health Services Program. The Medicaid rehabilitation options allow for providers to serve clients off-site and have a deferential rate to cover travel and other costs. PCHS is also Medicaid certified for substance abuse services. MHC and PCHS are both HIPAA compliant, a requirement for both state and local funding.

Project ACCESS leases space at the Champaign-Urbana Public Health District's (CUPHD) new location. This space will be renovated in consultation with youth and family members and be ADA compliant. It will house space for all ACCESS Initiative partners, including youth programs and the family organization. Its location is accessible to the target population and its proximity to public health facilities will be beneficial to many consumers. Services may also be offered through CUPHD's mobile wellness centers, churches, schools, the Housing Authority, libraries and at other ADA-compliant locations, increasing accessibility to clients in remote areas of the county or with limited transportation options.

SECTION D: EVALUATION PLAN

1. Evaluation Team

The evaluation team will cooperate fully with National Evaluation activities and the Government Performance and Results Act (GPRA). Drs. Nicole Allen and Mark Aber, evaluation co-directors, have extensive experience with community-based evaluation and longitudinal designs including tracking and retaining participants across multiple cohorts, and they routinely use both qualitative and quantitative approaches as appropriate to questions being investigated. Resources available include a) office space, b) computer networking capacity, c) data analysis software, and d) graduate and undergraduate research assistants. All University of Illinois research will be subject to review and approval by the University of Illinois Institutional Review Board (IRB) which is governed by the Office for Human Research Protections (OHRP). Finally, Drs. Allen

and Aber have extensive experience partnering with community members in evaluation projects focused on human service delivery innovations, and disseminating findings to multiple audiences (e.g., technical reports, community presentations, and peer-reviewed articles). The evaluation team is well positioned to comply fully with National Evaluation activities and GPRA requirements and to facilitate a local evaluation under contract with IDHS/DMH. The local evaluation will examine both processes facilitating (or impeding) the development of and outcomes resulting from a successful system of care (SOC). Such context-specific knowledge is central to developing and sustaining the ACCESS Initiative. As described below, data from both the national and local evaluations will be integral to the continuous improvement and sustainability of all aspects of the ACCESS Initiative.

2. Description of Evaluation Approach

a. Partnership – Evaluators will engage community partners in developing, finalizing, and executing local evaluation plans. An Evaluation Collaboration Team (ECT), co-chaired by a director of evaluation and a consumer, will meet at least monthly and include representation from all major system stakeholders, including evaluators, consumers (youth and adults), staff, and agency leaders. Collectively, ECT will identify evaluation questions, develop instruments and consent forms, gather and interpret data, and disseminate findings. Community partners will be a vital source of information regarding the cultural competence of the measures chosen and the most effective means of recruiting and retaining participants. Evaluators will engage consumers in all aspects of the research, from developing logic models to identifying outcome indicators to conducting interviews and assisting with analysis and interpretation. Further, we will seek new ECT members throughout the project to ensure representative participation. All evaluation plans developed by ECT will be reviewed and discussed by the governance body before dissemination.

b. Measures **–** The local evaluation will use existing measures when possible (sample measures are in Appendix 3). When a needed measure does not exist or is inappropriate for our purposes, we will develop or specifically tailor a culturally appropriate instrument to meet our needs. All measures will be piloted, in consultation with community members, to assess cultural relevance to target populations. When necessary, measures will be translated.

c. Data Collection **–** Most data collection proposed in this plan involves a longitudinal design. Data collection techniques will be tailored to target populations. For service providers, web-based surveys will be employed whenever possible to ease data distribution and processing. Consumer interviews will always be face-to-face and use structured or semi-structured measurement tools and participatory incentives. To the extent possible, interviewers will be community members who can relate to the perspective of ACCESS Initiative consumers. To begin data collection with consumers we will employ a two-stage process at baseline. Assessment tools (e.g., CANS) that provide a source of baseline data will be utilized by ACCESS Initiative staff conducting initial assessments. After this assessment, trained evaluation staff will interview consumers to gather remaining Time 1 data required by the National Evaluation; importantly, this interview will occur after assessment, but before intervention has begun. To encourage voluntary participation and free consumers to reflect honestly on service delivery experiences, evaluation staff – not service providers – will conduct follow-up interviews. Participation in the evaluation will be required for project organizations, but will be voluntary for consumers, staff, and agency leaders. The evaluation plan will assure that all GPRA requirements are met and will gather data on any performance measures not already covered in the National Evaluation plan, including: mental illness symptomatology, employment/education;

crime and criminal justice involvement; stability in housing; access (i.e., number of persons served by age, gender, race and ethnicity); rate of readmission to psychiatric hospitals or other institutional care; Social support/Social connectedness; and clients' perceptions of care. Existing tools will be utilized as provided through CMHS National Outcome Measures (NOM) Child Consumer Outcome Measures. Data will also be gathered from relevant systems as appropriate (e.g., child welfare, education, juvenile justice; see information on the development of an MIS below).

d. Data Management and Analysis– Office space, computers, and printers will be dedicated to this project. To protect the confidentiality of evaluation participants, data gathered and stored will use only an identification number. Identifying information will be stored in a separate locked office from data. Data will be entered into TRAC in full compliance with the National Evaluation and GPRA requirements and checked by two research assistants for accuracy. Confidentiality agreements preclude evaluation staff from sharing any evaluation related information. Data will be analyzed across a single point in time, across participants, and longitudinally allowing for ongoing reflection and feedback. The evaluation team will pursue a Federal Certificate of Confidentiality to further protect participants' rights.

e. Management Information Systems (MIS) – Community partners currently use a variety of web-based and internal databases for tracking, and Project ACCESS has developed a release form and database tool for tracking detention center pilot youth that includes basic demographic, service, outcome (e.g., recidivism). During the first year of the ACCESS Initiative, the partnership will focus on improvement of these tools for shared access, service reporting and evaluation. The Champaign County Regional Planning Commission is piloting a web-based database that can be expanded to include ACCESS Initiative information. Similarly, some partnering service agencies and state agencies already have comprehensive databases from which client and/or other types of data may be downloaded or linked for a more complete picture of each youth/family's services. This would be done with utmost attention to issues of confidentiality and privacy and would involve informed consent from families. An MIS Consultant will be used as necessary to build a state-of-the-art information system from our existing infrastructure and procedures, with the expectation that system partners will share data for improved integration of services and outcome measurement, with appropriate confidentiality levels for MIS users. Further, this data will be utilized to comply with GPRA requirements regarding criminal justice system involvement (e.g., recidivism), as well as educational (e.g., suspensions, expulsions) and child welfare systems to track rates of truancy, school disciplinary action, custodial terminations, and youth in foster care and inpatient facilities.

f. Tracking and Participant Retention **–** To ensure participant retention, we will develop a tracking protocol involving monetary incentives for participation, alternate contact information, and intensive efforts to locate participants modeled on the successful procedures used by Sullivan *et al. (*1996) to retain over 96% of 200 domestic violence survivors over two years.

g. Cultural Competence **–** Evaluation activities will maximize cultural competence by examining the relevance of our measures with different populations and by ensuring that our data collection techniques are appropriate. We will consult with youth and adult consumers and community members and the Cultural and Linguistic Competency Coordinator to make adjustments throughout the data collection process to accommodate the particular needs and wants of the groups receiving services.

h. Dissemination – Evaluation findings will be shared at least quarterly with both IDHS/DMH and the local community via reports, presentations, and dialogue forums. Also, data will be

summarized and provided in *Project 18 Report Card*, a publication which summarizes major local statistics concerning youth and families and has been widely used in local planning for over ten years. Both written and oral presentations will be developed and tailored for youth, parents, and staff. All reports will be approved by the governance body prior to release. Findings will also be disseminated more broadly (via conference presentations and publications) to advance knowledge regarding SOC development. IDHS/DMH will distribute evaluation findings statewide. National Evaluation reports will be shared as compiled data becomes available. Discussion about the implications of findings for developing the SOC will be facilitated thus the evaluation findings will serve to continuously inform and refine the local SOC development. Evaluations will be framed and conducted as *formative* with an improvement orientation. Evaluation activities will be reflexive throughout the project so that new questions can be addressed as they arise.

3. Description of Specific Evaluation Activities

a. Overview – Proposed local evaluation activities correspond to project objectives. These activities will be designed to avoid duplication with the National Evaluation. Thus, local plan will adapt as details of the National Evaluation are furnished. The local evaluation will gather data from a wide variety of informants, including consumers, community members, service providers, agency leaders, and the SOC administrative team and staff from Year 1 through Year 5. Given the centrality of shifting infrastructure to develop and sustain a SOC, the local evaluation will be devoted to assessing such changes, providing information regarding the implementation (i.e., the extent to which SOC is implemented as planned and when, why and how changes are made) and effects of the SOC. The proposed plan will evolve as the ECT begins to meet in the planning year.

b. Collaborative Efforts – The proposal emphasizes the development of a variety of collaborative bodies (e.g., Governance Body, administrative team, Family Organization, Wraparound Teams, etc.) to facilitate and govern SOC development, encourage coordination, and facilitate comprehensive service delivery to families. Given the central role of such committees in promoting service coordination (Foster-Fishman, Salem, Allen & Fahrbach, 2001), we will assess the development of collaborative efforts. This will involve: a) participant observation of meetings (when appropriate), b) analysis of meeting minutes to track committees' focus and progress, c) tracking committee membership and participation (focusing on inclusion of underrepresented groups and consumers), and d) examination of the quality of committee structure (e.g., leadership, membership) and climate (see Allen & Hagen, 2003, Butterfoss, 1998 for sample instruments). Examination of the new collaborative settings will provide information about how to strengthen efforts and overcome barriers to full development of a SOC. This portion of the evaluation will begin during Year 1, as collaborative settings are created. This portion of the evaluation is positioned to shed light on the barriers and achievement that result from interagency collaboration.

c. Interagency Linkages **–** As SOC development requires transformation of interagency linkages in the service of consumers, we will longitudinally track interagency exchanges including: a) referrals of clients, b) information exchanges, and c) resource sharing. This will be done by surveying a purposive sample of approximately 150 front line service providers within the SOC (including independent service providers such as psychologists in the community) about their interagency communication over the past month. In Year 1, to establish a baseline level of communication, provider staff will be surveyed twice in six-month intervals. They will then be surveyed yearly through Year 5. Purposive sampling will be accomplished by stratifying a

random selection of participants (obtained from staff lists of participating agencies) by level of involvement in the SOC (e.g., staff who regularly attend interagency meetings and/or participate in Wraparound teams as well as those with more peripheral connections), race/ethnicity, tenure in the agency, and department for which they work. Sampling strategies will be determined in consultation with agency informants. As SOC agencies become more tightly coupled, we expect an increase in coordination evidence by referrals and sharing of information and resources. We will use Social Network Analysis to model the density of networks that agencies form and examine these networks as they evolve over time. To augment information gathered from front line staff, we will interview administrators to assess formal agreements/linkages between agencies (such as fund pooling or cooperative service delivery agreements). This data collection will begin in Year 1 and occur yearly to assess changes for the duration of the grant. We expect joint ventures to increase in number over time. We will also assess staff identification with the SOC rather than with (or in addition to) their home organizations. This would provide one indicator of a move toward a seamless SOC. Finally, we will track who makes referrals to the SOC to examine how the referral network is growing (or failing to grow) and which agencies are engaged in team-based services for families to examine the breadth of the service agency network available to youth and families.

d. Staff Attitudes and Behaviors – Shifts in staff attitude, while difficult to accomplish, are often an important precursor in the implementation of new service delivery practices (Rogers, 1995). Thus, we will monitor staff attitudes toward the key elements of SOC service delivery (see Foster-Fishman et al., 1999 for sample instruments). We will also monitor the extent to which services are delivered in ways that are consistent with SOC principles (e.g., strengths-based approach, family-driven care, and cultural competency) by surveying the purposive sample of 150 staff described above about their attitudes and behaviors. We expect that as a SOC becomes established, staff will endorse more positive attitudes towards these SOC components *and* report a greater use of service delivery practices consistent with this approach (see Bailey et al., 1992 for a sample instrument). Finally, we will evaluate the effectiveness of training and technical support provided by the SOC to examine the extent to which such supports are facilitating shifts in staff attitudes and service delivery practices. Along these lines, pre and post "tests" will be distributed at all SOC training opportunities, and training experiences will be assessed in the course of longitudinal data gathering so that we can examine whether provider staff training influences their attitudes and behaviors toward greater alignment with SOC principles.

e. Organizational Contexts – While staff has some autonomy in how they serve clients, they are also bound by their organizational context. To understand how organizations may facilitate or impede implementation of a SOC, we will examine a variety of organizational variables. In their review of the papers on the National Evaluation of SAMHSA's SOC Initiative, Friedman and Hernandez (2002) called for better integration of system and individual level variables. Staff will be asked their perceptions of their organizations (e.g., the extent to which leaders, policies, and procedures encourage and support the adoption and implementation of a SOC; see Foster-Fishman et al., 1999 for a sample instrument). This will increase understanding of how service delivery agencies shape staff adoption and implementation of service delivery innovations (Foster-Fishman, Salem, Allen, & Fahrbach, 1999). We will also conduct annual interviews with members of each agency's administration (including board members) to analyze polices and procedures relating to the implementation of a SOC and to assess: a) attitudes and beliefs regarding the SOC model with attention to their agency's commitment to cultural competence

and consumer driven services, b) perceptions of other service providers in the community, and c) coordination arrangements with other service delivery agencies.

f. Consumer Involvement and Experiences **–** Consumers provide critical information regarding service accessibility, appropriateness, effectiveness, and fit to their needs. While a variety of outcome measures regarding consumers' health and well-being will be assessed via the National Evaluation, the local evaluation will focus on gathering data to illuminate how services are delivered and the extent to which they reflect the intended practices of the local SOC (e.g., the role of family advocates in engaging families). As required by the National Evaluation, interviews will be conducted with approximately 350 families (including youth and adults) purposively sampled from the population of families served in the SOC (sampling will be stratified by race/ethnicity, age and tier of service). Families will be interviewed as they enter the SOC and interviewed every three months during the first year of intervention and in 6-month intervals during the second year and third year of participation. At least one follow-up interview will occur six months after intervention has ended to add to the capacity of the evaluation to examine the durability of the intervention effects.

g. Outcomes **–** Given the stated purpose of the local initiatives, multiple consumer outcomes will be examined, including, for example, Service Delivery Outcomes, Mental Health Outcomes for "Target" Clients, and Family Functioning Outcomes (see Appendix 3 for an elaboration of these outcomes). These outcomes reflect both ultimate outcomes (e.g., changes in the target child's behavior) and intermediate outcomes (e.g., improved access to services; improved family functioning). Given the use of Wraparound in the SOC and Parenting with Love and Limits (PLL) as a best practice in the service array, the evaluation will attend to the desired effects of this approach (e.g., broader engagement of the natural support network). For example, in longitudinal follow-up with families we will track the density of natural support networks and the longevity of the network put in place by Wraparound. This should expand the research base supporting these approaches and the service delivery elements associated with positive changes for families. Importantly, all information required by GPRA will be gathered and local measurement will be careful not to duplicate, but plan to augment what is already gathered via the National Evaluation. Further, the examination of youth and family outcomes will attend to individual (e.g., race/ethnicity, age, SED) and contextual (e.g., intervention approach, service array, Social support) sources of variability in outcomes (see Process below for additional information on contextual factors).

h. Process **–** Process data provides a valuable "implementation check" by gathering information on how services are offered from clients' perspectives. Such data will be gathered from families in the time intervals described above to assess youth and parental (or caregiver) perceptions of the ACCESS Initiative. The evaluation will also examine the accessibility of services to consumers; this outcome is critical given the emphasis on employing Family Advocates to support and engage families in the SOC. Further, we will examine consumer involvement in the service delivery process – both as service providers (when applicable) and consumers. Finally, for each participating family the evaluation will record critical service delivery elements, including, for example: the composition of Wraparound Teams; service intensity and duration; provider characteristics; service delivery context; and overall cost. Tracking such information will assist in the assessment of what services were provided, by whom, to whom, in what contexts, etc. This information will be part of the expansion of the MIS used by the SOC. This will assist us in examining how varied contexts and service approaches relate to outcomes for youth and families.

In Year 1, qualitative data will be gathered from a purposive sample of system clients to augment process data, capture current baseline practices, and assess youth and family needs (see Trivette, Dunst, & Hamby, 1996 for a sample instrument). As the system becomes established, we would expect perceptions to reflect the primary elements of SOC service delivery (e.g., seamlessness, strengths-based, cultural competence, etc.); thus, in Year 6 similar cross sectional data collection techniques will examine shifts (or lack thereof) in the experiences of families involved in the ACCESS Initiative. In addition, given Champaign County's assessment by the National Wraparound Institute, the evaluation team will work with the Institute to track how Wraparound benchmarks shift over time. In planning our evaluation activities, we will take care to avoid burdening individuals with multiple research involvements.

To further assess cultural competence, access to services, retention of youth from underserved communities and changes in staff efficacy in working with special populations after cultural competence trainings will also be measured. Process data will be collected concerning outreach to underserved populations, calls and follow-ups, information dissemination, and the types of interventions conducted to reduce structural barriers (e.g., transportation, childcare, etc.).

4. Description of Plans to Insure Continuous Improvement

While evaluating infrastructure changes and consumer experiences provides multiple sources of information regarding how to continually improve the SOC, we are planning at least three efforts to insure a continuous orientation to system improvement. First, our evaluation coordinator will compile reports regarding the service delivery process and families' reported experiences at least quarterly. Such reports will involve attention to fidelity in efforts to achieve a SOC. Second, we will train service providers and families to assess the fidelity of the service delivery process on a regular basis by completing a brief form after meetings of the Wraparound team (e.g., the Milwaukee Wraparound Self-Assessment Tool, the Youth Self-Efficacy Scale, and/or the Youth Participation in Planning Scale). Building this assessment process into training will incorporate the core elements of a SOC. In practice, this provides both an immediate opportunity for self-assessment regarding SOC elements and an additional source of data regarding intervention fidelity. Finally, throughout the process we will conduct interviews with members of the SOC administrative team. Individuals in multiple roles within the developing system will be interviewed regarding their perceptions of what is working well, what barriers are emerging, how such barriers can be overcome, and how current strengths can be developed. To ensure continuous quality improvement, the evaluation project coordinator will work closely with the governance body to provide formative evaluation information that can help to improve the service delivery process as the SOC is developed and implemented.

5. Description of Evaluation of Sustainability

The SOC aims to change the infrastructure of the service system such that the SOC is not dependent on continued federal funding. Ideally, “service as usual” will be transformed in the community to reflect SOC values. Thus, a wide variety of systems indicators will be identified (in collaboration with ECT and the governance body) to examine the sustainability of the SOC effort. Changes in each indicator will be examined to assess the extent to which the service system infrastructure is reformed. Indicators will be tracked as part of the evaluation strategies outlined above and may include, but are not limited to, funding priorities that encourage seamless service delivery, staff identification with the SOC, density of interagency linkages, resource sharing and joint ventures, staff attitudes and behaviors consistent with SOC principles, decreased disproportion of African Americans involved in the juvenile justice system, increased diversity of consumers served, increased satisfaction among formerly underserved consumers,

decreased gaps in service delivery as experienced by consumers, and increased centrality of cultural competence in service delivery agencies (see Appendix 3 for a more complete list of such markers). The extent to which these indicators change as desired suggests potential for sustaining the SOC over time. If any indicators remain static, it will alert us to areas that have been resistant to change and require more concerted focus. Finally, given the influence of the "external environment" (i.e., factors outside of the service system) to shape the success of reform efforts (e.g., Foster-Fishman, Salem, Allen, & Fahrbach, 1999), we will also assess the presence of support for the SOC from key community leaders (e.g., local government endorsement of SOC efforts, continued funding and support from the Champaign County Mental Health Board) and increased funding sources to support the SOC. Interviews with key leaders and funders will be completed in Years 1, 3, and 5 to assess the presence of such support. In addition, participant observation will occur at Mental Health Board meetings to track funding priorities related systems of care.