

APPLICATION FOR FEDERAL ASSISTANCE

SM05-10

703

1. TYPE OF SUBMISSION:
Application

- Construction
 Non-Construction

- Pre-application
 Construction
 Non-Construction

2. DATE SUBMITTED
05/13/2005

3. DATE RECEIVED BY STATE

4. DATE RECEIVED BY FEDERAL AGENCY

Application #: 1 U79 SM57024-01
PD: Ford, George
Council: 10/2005
Receipt Date: 05/16/2005

5. APPLICANT INFORMATION

Legal Name: Harris County, Texas		Organizational Unit: Department: Harris County Protective Services for Children & Adults	
Organizational DUNS: DUNS#07220637		Division: TRIAD Prevention Program	
Address: Street: 2525 Murworth		Name and telephone number of the person to be contacted on matters involving this application (give area code)	
City: Houston		Prefix: Mr.	First Name: George
County: Harris		Middle Name:	
State: Texas	ZIP: 77054	Last Name: Ford	
Country: USA		Suffix: J.D.	

MAX 16 2005

6. EMPLOYER IDENTIFICATION NUMBER (EIN):
76-0454514

Phone Number (give area code): (713) 394-4070
FAX Number (give area code): (713) 394-4150

8. TYPE OF APPLICATION:
 New Continuation Revision

If Revision, enter appropriate letter(s) in box(es):
(See back of form for description of letters)

Other (Specify): Cooperative Agreement

7. TYPE OF APPLICANT (See back of form for Application Types):
B. County
Other (Specify):

9. NAME OF FEDERAL AGENCY:
SAMHSA-CMHS

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER:
93-104

11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:
Harris County Alliance for Children and Families
TITLE (Name of Program): Child Mental Health Init./SM-05-10

12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.):
All of Harris County

13. PROPOSED PROJECT:
Start Date: 09/01/2005
Ending Date: 08/31/2008

14. CONGRESSIONAL DISTRICTS OF:
a. Applicant District 18
b. Project 7,8,9,18,22,25,29

15. ESTIMATED FUNDING:		16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS? a. <input checked="" type="checkbox"/> YES. THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON. DATE: _____ b. <input type="checkbox"/> NO. PROGRAM IS NOT COVERED BY E. O. 12372 OR PROGRAM HAS NOT BEEN SELECTED STATE FOR REVIEW
a. Federal	\$999,959.00	
b. Applicant	\$468,340.00	
c. State	\$0.00	
d. Local	\$92,500.00	
e. Other	\$17,000.00	
f. Program Income	\$0.00	
g. TOTAL	\$1,577,799.00	17. IS APPLICATION DELINQUENT ON ANY FEDERAL DEBT? <input type="checkbox"/> YES If "Yes," attach an explanation. <input checked="" type="checkbox"/> No

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT, THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.

a. Authorized Representative

Prefix Honorable	First Name Robert	Middle Name A.
Last Name Eckels		Suffix
b. Title Harris County Judge		c. Telephone Number (give area code) (713) 755-4000
d. Signature of Authorized Representative		e. Date Signed

ABSTRACT

Harris County Protective Services for Children and Adults (HCPS), in collaboration with Harris County Juvenile Probation (HCJPD), Mental Health and Mental Retardation Authority (MHMRA) of Harris County, family groups, and various community and state health department partners, proposes to create a single, integrated family driven and culturally/linguistically competent system of care for Harris County, Texas, youth with serious emotional disturbances (SED) and their families. To achieve that goal, these partners will collaborate with other local family groups and numerous public and non-profit organizations that develop and expand a family driven and youth guided SOC using wraparound processes. HCPS TRIAD Prevention Program will provide administrative and fiscal management of the Harris County Alliance for Children and Families, our local system of care.

Building upon the multi-agency Harris County Alliance for Children and Families collaborative successes and lessons learned since 2000, we will continue to promote major systems transformations. These include:

- Promotion of system integration by development of an Alliance Governing Board and including family members and representatives from public and private child-serving agencies. The Board will 1) provide policy leadership and develop memoranda of agreements between the Harris County Alliance and local / state entities to expand and sustain the Alliance, 2) develop a comprehensive strategic plan to guide the SOC process, and 3) pool blended funding to purchase non-traditional supports and services.
- Promotion of service integration by expansion of the Harris County Alliance Resource Coordination Team (ARCT), a multi-agency group responding to the complex physical and mental health needs of Harris County youth at risk for out of home placement. The ARCT will serve as the point of entry for 100 Harris County youth with SED per year referred by a wide variety of community referral sources beginning in Year 2. The ARCT will also promote expansion of a comprehensive ethnically diverse service and support network, and work towards maximum utilization of diverse public and private funds.
- Promotion of SAMHSA system of care core values and guiding principles through an extensive training and technical assistance program aimed at parents, service providers, as well as current and future health service providers. Family members will serve as co-faculty in all trainings.
- Comprehensive evaluation of the Harris County Alliance system of care resulting in broadening the SAMHSA promotion of evidence-based practice and knowledge, and leading to continuous quality improvement of the Harris County Alliance SOC.

In Year 1 (FY2005-06), the Harris County Alliance requests \$1 million under this collaborative agreement to develop, promote and sustain the local SOC infrastructure, to support training and technical assistance, to build local family group capacity, and to evaluate national and local outcomes. The Alliance will develop a social marketing plan to increase community support for our local SOC and reduce stigma. A local child advocacy agency will advocate for increased local, state, and federal funding for children's mental health including Medicaid waivers and CHIP expansion of mental health coverage for Texas children.

**Harris County Protective Services
Houston, Texas
DEPARTMENT OF HEALTH & HUMAN SERVICES
SAMHSA Center for Mental Health Services
Request for Application RFA No. SM-05-010**

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BUDGET INFORMATION - Non-Construction Programs

SECTION A - BUDGET SUMMARY						
Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. SAMHSA-CMHS	93.104	\$ 999,959.00	\$ 171,257.00	\$	\$	\$ 1,171,216.00
2.						0.00
3.						0.00
4.						0.00
5. TOTALS		\$ 999,959.00	\$ 171,257.00	\$ 0.00	\$ 0.00	\$ 1,171,216.00
SECTION B - BUDGET CATEGORIES						
6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total (5)	
	(1)	(2)	(3)	(4)		
a. Personnel	\$ 275,749.00	\$ 119,020.00	\$	\$	\$ 394,769.00	
b. Fringe Benefits	97,450.00	35,237.00			132,687.00	
c. Travel	29,420.00	0.00			29,420.00	
d. Equipment	64,100.00	0.00			64,100.00	
e. Supplies	18,700.00	0.00			18,700.00	
f. Contractual	487,800.00	17,000.00			504,800.00	
g. Construction	26,740.00	0.00			26,740.00	
h. Other	0.00	0.00			0.00	
i. Total Direct Charges (sum of 6a - 6h)	999,959.00	171,257.00	0.00	0.00	1,171,216.00	
j. Indirect Charges	406,583.00				406,583.00	
k. TOTALS (sum of 6i and 6j)	\$ 1,406,542.00	\$ 171,257.00	\$ 0.00	\$ 0.00	\$ 1,577,799.00	
7. Program Income		\$ 0.00	\$ 0.00	\$	\$	\$ 0.00

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8. SAMHSA-CMHS Child Mental Health Initiative	\$ 468,340.00	\$ 0.00	\$ 109,500.00	\$ 577,840.00
9.				0.00
10.				0.00
11.				0.00
12. TOTALS (sum of lines 8 and 11)	\$ 468,340.00	\$ 0.00	\$ 109,500.00	\$ 577,840.00

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	\$ 999,959.00	\$ 249,989.75	\$ 249,989.75	\$ 249,989.75	\$ 249,989.75
14. Non-Federal	171,257.00	42,814.25	42,814.25	42,814.25	42,814.25
15. TOTAL (sum of lines 13 and 14)	\$ 1,171,216.00	\$ 292,804.00	\$ 292,804.00	\$ 292,804.00	\$ 292,804.00

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

(a) Grant Program	FUTURE FUNDING PERIODS (Years)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16. SAMHSA-CMHS Child Mental Health Initiative	\$ 1,500,000.00	\$ 2,000,000.00	\$ 2,000,000.00	\$ 1,500,000.00
17.				
18.				
19.	\$	\$	\$	\$
20. TOTALS (sum of lines 16 - 19)	\$1,500,000.00	\$2,000,000.00	\$2,000,000.00	\$1,500,000.00

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:	22. Indirect Charges:
23. Remarks	

SECTION A: UNDERSTANDING THE PROJECT (15 points)

1. Literature Review:

On July 22, 2003, the President's New Freedom Commission on Mental Health responded to President Bush's declaration a year earlier, "Our country must make a commitment. Americans with mental illness deserve our understanding and deserve excellent care". The Commission's charge was to study the mental health service delivery system, and make recommendations that would enable adults with serious mental illness and children with serious emotional disturbance to live, work, learn, and participate fully in their communities. Their final report, *Achieving the Promise: Transforming Mental Health Care in America* (2003), recommends a fundamental **transformation** of the Nation's approach to mental health care, promotes a **system of care** philosophy in facilitating that shift, and builds upon similar recommendations from numerous sources.

Principles of systems of care: A system of care (SOC) is defined by Stroul and Friedman (1994) as "a comprehensive spectrum of mental health and other necessary services that are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with serious emotional disturbances (SED) and their families". This involves a multi-agency, public/private approach to delivering services, an array of service options, and flexibility to meet the full range of needs of children, adolescents, and their families.

A System of Care for Severely Emotionally Disturbed Children & Youth (Stroul & Friedman, 1986, 1994) serves as a conceptual framework for system of care development and is referred to as the "blueprint for action" in the child mental health field (Stroul et. al., 1992). The SOC model actually represents a **philosophy** about the delivery of mental health services and supports to children and their families. Standing on a foundation of shared values, a system of care is:

1. **youth-guided, family- driven and strengths based**, with the needs and strengths of the child and family dictating the types and mix of services provided.
2. **community based**, with the locus of services, management and decision-making responsibility resting at the community level.
3. **culturally and linguistically competent**, with agencies, programs and services that are responsive to the cultural, racial and ethnic differences of the populations they serve.

The array of services are: comprehensive, individualized for the child and family, provided in the least restrictive setting, inclusive with involvement of families and youth as full partners, and invested in early identification and intervention. The SOC model is organized around eight major dimensions which include: mental health services; social services; educational services; health services; substance abuse services; vocational services; recreational services; and operational services (Stroul & Friedman, 1986). In 2005, the consensus in the field of child and adolescent mental health embraces the concept that community-based systems of care for youth with SED and their families are needed. The development of these systems has become a national goal.

History of Systems of Care in the United States: Systems of care for children and adolescents with mental health problems have been of great interest over the past two decades (Stroul, Lourie, Goldman & Katz-Leavy, 1992). *Unclaimed Children* (Knitzer, 1982), a documentation of the status of children's mental health in America, revealed the failure of child and adolescent service delivery systems to provide adequate and appropriate care of the increasing numbers of children and youth with, or at risk of developing SED in the United States. Knitzer estimated that of the three million children with SED, two-thirds were receiving no treatment and many others were receiving inappropriately restrictive care due to the lack of community-based service alternatives. Almost 20 years later, the *Surgeon General's Report on Mental Health* (2000) further indicated that youth with SED have received insufficient treatment; providers have overly utilized institutional care for treatment; and institutional care that has been provided has had harmful consequences for children

and youth in care and their families. The Report indicates that despite national, state and community efforts to create **systems of care**, we continue to face a public crisis in mental health for children and adolescents.

In response to the problems uncovered by Knitzer and increasing calls for change, the National Institute of Mental Health initiated the Child and Adolescent Service System Program (CASSP) in 1984. The goal was to assist states and communities in creating community-based systems of care for children and adolescents with SED by developing interagency efforts to improve and expand services. CASSP supported system of care building through grants and technical assistance, and by 1992 these initiatives were evidenced in every state. Authorized by the Public Health Service Act in 1992 and built on the principles of the Child and Adolescent Service System Program (CASSP), the Comprehensive Community Mental Health Services for Children and Their Families Program (CMHS) currently promotes the development of service delivery systems through a system of care approach. Since its inception, more than 22 communities have completed their performance period. Currently 65 CMHS children's services projects are being actively evaluated across the country.

The growth in local, state and national organizations focused on children's mental health issues has been aided by support from state mental health authorities, local and state mental health associations, state and local chapters of the Alliance for the Mentally Ill, and private foundations (Friesen, Griesbach, Jacobs, Katz-Leavy, & Olson, 1988). The Robert Wood Johnson Foundation's Mental Health Services Program for Youth provided substantial funds for the development of systems of care in selected local areas and for extensive system development initiatives in a number of states. As a result, the concept has progressed to a level at which it can be effectively described and studied (Lourie & Stroul, 1996; Stroul et al, 1992). In 1993, the Annie E. Casey Foundation began *Mental Health Initiative for Urban Children*, which focused system-building efforts at the neighborhood level in inner cities, including Houston, TX (Pires, 2002).

Need for systems of care reform in the United States: Nationally, youth with SED have complex needs cutting across traditional lines of responsibility and through the categorical funding silos of child serving agencies. Each system was designed, however, to meet specific, categorical needs despite the fact that they serve the same children and families. Strides have been made toward achieving a systems of care vision, but many areas remain undeveloped. As noted by Stroul (2002), improved access to mental health services, engagement of children and families, cost-effective services, efficient treatment interventions, integrated care, attention to cultural differences and increased resource investment are included.

The increasingly high cost of services is also a barrier to families who can neither access the public funding system nor afford to pay for services individually or through limited insurance coverage. Of the \$137 million in federal funds devoted to children's mental health in 1998, only three percent was spent on early identification and intervention (Greenberg, et al., 2001) with 97 percent spent on high-cost services for youth with SED, a group that comprises the smallest percentage of children receiving mental health services (Jerrell, 1998). Transformation of mental health delivery to children and youth with SED and their families is needed nationally, as well as in Harris County, Texas.

Need for systems of care reform in Harris County: Harris County, Texas is the third largest county in the United States with a population of over 3.5million residents (almost 1.5 million are children 18 and under). Approximately 115,000 Harris County children are likely to meet criteria for SED. Harris County does not have a seamless youth guided and family driven, culturally/linguistically competent community-based system of care for our children/youth with SED and their families. Our community does, however, have an existing infrastructure that would support a local system of care for children/youth with SED and their families, including:

- a wide variety of children's mental health services and supports financed through local, state and federal funding including Medicaid, CHIP, TANF, and federal qualified clinic funds,
- a strong history of inter-government agency collaboration to deliver services to children and families (TRIAD agencies = Harris County Protective Services for Children & Adults, Harris County Juvenile

Probation Department and Harris County Mental Health Mental Retardation Authority of Harris County; relationships with state-level health and human services agencies) and

- a state-mandated multi-agency community resource coordination group (CRCG) to provide coordination of services to children with multi-agency needs.

In 2003 the Harris County Alliance for Children and Families (AKA the Alliance) was formed from the merger of the Houston Integrated Funding Initiative (HIFI) and the Harris County Community Resource Coordination Group (CRCG), two local collaboratives interested in systems of care development. Although the Alliance has taken steps in engaging families and agencies in developing a local SOC vision, we need assistance in developing an infrastructure strong enough to effectively and efficiently *transform* our current children's mental health service delivery system to a cohesive SOC for our children and youth with SED and their families.

2. Description of Population of children with SED in Harris County:

Projected age range: The children and youth receiving services from the Alliance for Children and Families will be from birth (0) to 21 years of age.

Prevalence estimate of children with SED within Harris County: There are approximately 1,042,865 children and adolescents (18 and under) living in Harris County. The most recent Harris County Mental Health Needs Council report (2003) indicates that: 11% (n=114,715) of Harris County children and adolescents are likely to meet criteria for SED and 2% (n=20,857) are likely to need public mental health services.

Estimated percentages of children and families from racial and ethnic groups: With a total population of 3,596,082, (U.S. Census, 2003) Harris County is the third most populated county in the nation and the first among Texas counties. It is culturally diverse with 42% Caucasian, 18.5% African-American, 33% Hispanic, and 5% Asian peoples. (*Texas Kids Count: The State of Texas Children 2003*).

Of the 1,042,856 children and adolescents living in Harris County, 33% are Caucasian (n=344,142), 20% are African-American (n= 208,571), 42% are Hispanic (n= 438,000), and 5% (n= 52,142) are Asian and other races (*Texas KIDS Count 2003*). The fastest growing segments of the population are Hispanic and Asian.

Other demographic characteristics of children and their families:

Total Harris County population is 49.8% male and 50.2% female, with a median age of 31 years (2000 Census). In 2002, the unemployment rate for Harris County was 6.1% and average household income was \$42,598 (*Texas KIDS COUNT 2003*). Harris County has a child poverty rate of 19.9% and 3.3% of local families receive Texas Aid to Needy Families (TANF) funds. While population growth and economic boom have enhanced the overall wealth and employment opportunities of our community, these factors have also resulted in greater economic disparities and a rise in uninsured citizens (Nguyen & Hickey, 1999), many who are children. Approximately 10.1% of Harris County children were enrolled in Special Education classes, and 18.2% of Harris County children were enrolled in Bilingual/ESL programs. (*Texas KIDS Count 2003*). As of March 2005 there were 299,426 Harris County children and adolescents enrolled in the Texas Medicaid program and 64,860 Harris County Children's Health Insurance Plan (CHIP) enrollees. The public safety net for these children and adolescents is not capable of serving such large numbers now or in the years to come (*TX Health & Human Services Commission website*).

Sources of Potential Referrals: Approximately 75% of Harris County children live in families with both parents present in the home, and with 25% living in families headed by a single parent. However, the majority of Harris County children and youth with SED served by the Alliance reside in single parent households and receive a wide variety of services and supports. Children may be in special education programs and mental health services through 24 local school districts, Harris County Juvenile Probation Department (HCJPD), Mental Health Mental Retardation Authority of Harris County (MHMRA), public and private psychiatric in and out-patient programs, public and private health and mental health clinics or providers, and other mental health

providers. We project that referrals will be made to the Alliance from the following sources: 1) schools and Harris County Protective Services (HCPS) Community Youth Services school-based social workers; 2) HCJPD mental health programs; 3) MHMRA Children's Division; 4) Baylor College of Medicine/Ben Taub Hospital Children's Psychiatric Clinic; and 5) other mental health providers and self-referrals.

Other Population Characteristics Impacting Access and Service Delivery:

Language: The primary language used in Harris County is English. Spanish is, however, the preferred language of hundreds of thousands of Harris County residents making delivery of mental health services in their primary language difficult to achieve.

Level of acculturation, migration and immigration characteristics: Houston, Harris County, Texas is home to a large number of recent immigrants from all over the world. Over 50% of immigrants are Hispanics from Mexico, Central and South America who come to Houston to escape poverty in their countries. Once in the county the only jobs available to them are service and construction jobs with low pay and few if any benefits, again placing them in positions of poverty and with little access to community resources such as medical insurance for their families. We are also home to many first generation Asians who present special issues, particularly language barriers. There are approximately 151,000 Asian Americans in Harris County and that number is expected to double by 2025. Approximately 80% are recent immigrants.

Service disparities: Immigrant and first generation children face poverty, discrimination, limited language skills and lack of access to quality health care and education resources. Notably, racial and ethnic minority groups are generally considered to be underserved by the mental health services system. As a result, minorities experience more negative outcomes from the effects of mental illness. (Mental Health Association in Texas, June 2002). Service disparities include: less access and availability of mental health services, inaccurate diagnoses, overall poorer quality of mental health care, and inadequate culturally/linguistically competent services especially for non-English speaking families.

The 2001 Surgeon General's Report indicates that while overall rates of mental illness for Hispanic Americans is similar to that of Caucasians, Hispanic youth exhibit higher incidence of depressive and anxiety symptoms, and higher rates of suicide ideation and attempts. Although Hispanics are the majority of Harris County youth, mental health services are underutilized by these youth and their families. Many are underinsured and uninsured, and do not have access to either public or private services, resulting in disparity of care for these children and adolescents. Language barriers, residency requirements and stigma often make delivery of services difficult if not impossible for these families. These barriers have resulted in Harris County, public agencies showing trends of over-representation of African-American and Hispanic youth in public juvenile justice, child welfare and mental health systems as indicated in Table 1.

Table 1: Ethnic Representation of Youth in Harris County Public Service Systems

FY2004	African American	Hispanic	Caucasian	Asian	Other
MHMRA	2003	2091	1631	43	38
HCJPD	5367	5239	4505	(in Other)	218
HCPS/HCPS	18,856	9791	6890	(in Other)	725
TCOJMS Juvenile Mental Health	53	40	28	1	1

3. Current Capacity to Serve Children with SED & their Families:

Although a growing number of prevention programs for Harris County children and adolescents are being funded by public and private monies, the majority of DIRECT services and supports to children with severe mental health needs is still managed by five major public systems:

A. Child Protective Services: In 2003, a total of 6,402 Harris County children were confirmed to have been abused or neglected, and 1,819 were taken into protective custody by the Texas Department of Family

and Protective Services (DFPS). Consequently 1,357 foster children ages 0-17 entering into foster care were provided mental health assessments through the HCPS Children's Crisis Care Center. Recommendations for further mental health services were made for the majority of those children. Those services included psychiatric and/or psychological evaluations, counseling, and Early Childhood Intervention services for children ages 0-3. HCPS provided information, referral and/or counseling services and other health-related services to 28,543 children and adolescents in the Community Youth Services (CYS) program, 21,564 in the TRIAD Prevention Programs, 319 in the Chimney Rock Center Emergency Shelter, and 5,218 clinic visits in the HCPS Medical-Dental Clinic. (*Protective Services in Harris County Annual Report, 2004*). HCPS is a Medicaid and CHIP provider.

Children's Assessment Center is a Harris County youth services agency that provides services specifically to children and youth who have been sexually abused. In FY 2003, there were 5,015 alleged victims of sexual abuse (14.2% of all local child abuse reports). These children/youth are medically and psychologically assessed and then provided ongoing mental health supports such as individual, group and/or family counseling, and medical management as needed.

Harris County Alliance For Children and Families: (formerly the Harris County Community Resource Coordination Group [CRCG]): In 1992 the Texas legislature mandated that each Texas county establish an interagency council to develop a coordinated plan of service for children and youth who have complex psychological and/or medical needs and who are risk of out-of-home placement. This multi-agency collaboration would review requests for, and fund, residential placements for these children and youth. Harris County responded by forming the Harris County CRCG. Many youth referred to CRCG were receiving services and supports through at least two of the partner service agencies, and were at-risk for out of home residential placement due to severe emotional and/or behavioral disturbances. In 2000, Harris County Mental Health Association received a Texas Integrated Funding Initiative state grant to develop a school-based pilot project utilizing a system of care approach. Harris County CRCG became the service coordination system for that initiative, known as the Harris County Integrated Funding Initiative (HIFI). In 2003 CRCG and HIFI merged and formed the Harris County Alliance for Children and Families. The Alliance is now the point of entry for children and youth with SED referred from a variety of sources for least restrictive comprehensive supports and services, and provides coordination and case management services based on system of care principles. The Alliance is administered by HCPS TRIAD Prevention Program with pooled residential and flex funding from the TRIAD public agencies (HCPS, HCJPD, MHMRA). Though the formation of the Alliance has moved the county a step closer to a system of care approach, much coordination and collaboration with all providers remains to be done.

In FY 2003-04, the Alliance received 190 referrals. Age ranges included: 0-9= 26; 10-15= 108; 16+ = 156. Referral sources included: Independent School Districts = 101; MHMRA Child & Adult Services: 20; MHMRA Mental Retardation: 23; State Schools = 27 ; TRIAD Prevention Services = 5; Community Youth Services = 6; TDPRS = 2; Self referred/other = 5.; HCJPD = 1. The Alliance reviewed 215 referrals: permanency plans = 26; notifications of admissions to out of home placements = 20; referrals to intensive in-home therapy = 9; referrals to Systems of Care wraparound project = 13; referrals for non-ed funds review; referrals for staffing for community and home support = 49; referrals for residential treatment = 7. The Alliance service toolkit includes referral and payment for residential treatment (funded by TRIAD agencies), intensive in-home services (MHMRA funded), crisis respite services (MHMRA funded), advocacy services (funded by reappropriation of some TRIAD residential treatment funds), and wraparound planning services (funded by TIFI/HIFI grant funds).

B. Mental Health /Mental Retardation Authority: MHMRA of Harris County is the local public sector mental health agency and is a Medicaid and CHIP provider. In 2003-04, MHMRA's Children and Adolescents Services (CAS) program served 4585 youth in community-based programs. Of these, 4,355 youth had a

Global Assessment of Functioning score under 50, indicating serious symptoms; 1,676 were at placement risk; 1976 were in the juvenile justice system, and 525 were in special education classes. Services included: Medication-related (n=2872), service coordination (n=2490), hospital/crisis stabilization (n=280), skills training (n=3027), counseling (n=1089), family training services (n=440), and acute day treatment (n=58). MHMRA operates a 24-hour emergency psychiatric hospital: the Neuro-Psychiatric Center (NPC) at Ben Taub Hospital. The NPC also operates a 23-hour observation program designed to provide an alternative to inpatient hospitalization, and served 784 youth in 2004.

Additional inpatient child stabilization services are available through the University of Texas - Harris County Psychiatric Center (UT-HCPC). In FY 2003-04, there were 545 admissions to child/adolescent units. The Harris County Juvenile Probation Department (HCJPD) invested over \$1.9 million in the UT-HCPC Juvenile Justice Sub-Acute Unit to provide 16 hospital beds for juveniles who exhibit the most serious mental health problems. In 2003-04 there were 79 admissions to the JP unit, and 466 admissions to the other UT-HCPC child/adolescent units. Implementation of a total system of care approach is expected to save dollars currently spent on inpatient stays and provide services enhanced serviced to keep children and families together.

The MHMRA Mobile Crisis Intervention Team and the Houston Police Department Crisis Stabilization Unit respond to in-home mental health crises and provided needed supports to ensure safety and stabilization to 91 youth in 2003-04, thus minimizing inpatient hospitalization or incarceration.

C. Juvenile Justice: Harris County Juvenile Probation Department (HCJPD) continues to represent a growing population, with increased numbers of probationers requiring mental health care. In 2004, HCJPD received 26,072 referrals for violation of the law. The total budget was \$62,676,911 and of that budget, approximately \$6 million was allocated for mental health categories for counseling contracts, substance abuse treatment, sex offender treatment, and psychological evaluations. In FY 2004, **1,989 juvenile offenders were evaluated for mental health needs, and 1,393 received mental health services.** Of those, 404 youth received psychiatric treatment and 348 received individual therapy. The remainder (641) were served through skills groups. MHMRA has expanded community-based mental health services in Juvenile Probation facilities through increased funding for the First Offenders Program and the Choices Program. The Texas Council on Offenders with Mental Impairments (TCCOOMI) project addresses mental health needs of juvenile offenders with SED. In FY 2004, TCCOOMI provided services to 182 juveniles (male = 146, females = 36). In FY 2004, there were 155 admissions to the sub-acute JP unit at HCPC. HCJPD is a Medicaid and CHIP provider.

D. Public Education systems: Harris County has 24 Independent School Districts (ISDs) which provide special education services to children ages 3 to 21. Mandated by the IDEA to provide for services and supports to youth with special needs, they are legislatively mandated to conduct individualized plans of service for each child with special needs, and provide funding as needed to ensure children success in schools. Local schools were the largest Alliance referral source for children with mult-agency special needs children (101 children in FY2004).

E. Primary Health Facilities: Harris County children and youth with SED are often provided mental health services through emergency rooms, health clinics and physicians' offices. Gateways to mental health treatment are primary health care providers such as: the Harris County Hospital District (9 federally qualified health clinics, 23 county health clinics, Ben Taub General Hospital and emergency room; Baylor College of Medicine Child Psychiatry Clinic in Ben Taub Hospital; Lyndon Baines Johnson General Hospital and clinics); City of Houston and Harris County Department of Health community health centers and clinics; six Baylor College of Medicine Teen Clinics located in 5 high schools and Ben Taub Hospital; Texas Children's Hospital; Baylor College of Medicine Child and Adolescent clinics; University of Texas Mental Health Sciences

and Medical clinics for children and adolescents, and local hospital emergency rooms. All are Medicaid and CHIP providers. Thus far in FY 2005, a total of 3,085 unduplicated children with mental health primary and secondary diagnoses have been seen by the Harris County Hospital District. Of those, 266 youth ages 0-18 were hospitalized in one of two county general hospitals.

In addition, Harris County youth with SED are served by **Residential and Community –Based Providers**. Local **residential** mental health services for children include Devereux Texas Treatment Network and IntraCare Hospitals. Several private not-for-profit agencies provide **community-based** mental health services to children and families, including DePelchin Children's Center (DCC), Catholic Charities, Family Services of Greater Houston, The Houston-Galveston Institute, and Youth and Family Counseling Services as well as many smaller agencies and private practitioners. DCC is the largest Harris County private multi-service child and family agency, and provides traditional out-patient mental health counseling services to more than 5,000 local children and their families annually. DCC has agreed to be an Alliance partner and is a Medicaid provider (see letter of agreement).

4. Local Gaps, Inadequacies & Barriers to Systems of Care: Although Harris County is a major metropolitan area with numerous resources, many of our children and youth with SED are unable to access the supports and services they need to live, study and thrive in our community. Several local community assessments and input from various consumers and providers in April 2005 revealed the following:

Gaps include:

- No **interagency strategic plan** for Mental Health Services for Harris County children
- No **collaborative efforts between public & private health/mental health service systems** on a policy-making level re: systems of care.
- No **ethnic specific provider network**, including natural supports from diverse communities;
- No formal system of service providers integrated into a **coordinated array of mental health services** for kids with SED & families.
- No legislative mandate that agencies must **coordinate resources** for kids with SED & their families
- No formal **training / outreach to interdisciplinary health professionals**
- No interagency Management Information System (**MIS**), interagency standardized data collection, intake/assessment, or longitudinal tracking of clients outcomes.

Inadequacies include:

- Inadequate **coordination** of mental health services among child-serving entities (schools, medical providers, social service agencies, juvenile justice, faith-based initiatives);
- Inadequate **family involvement** in policy-making and service delivery; inadequate family support networks in accessible community settings; inadequate resource support for family organizations.
- Inadequate **"blended funding"** from public and private agencies, service providers and families; inadequate funding for "non-traditional" system of care services;
- Inadequate use of non-traditional care providers and **culturally competent services**;
- Inadequate day treatment, in-home family support, therapeutic foster care, respite services, after-school programs; transitional services.
- Inadequate **capacity of public mental health services** to serve large numbers of youth with SED and their families, thus making primary health care the gateway and provider of mental health services to local youth;
- Inadequate **substance abuse prevention / treatment programs** for youth with SED.
- Inadequate **transitional planning** for youth into adult mental health services.

Barriers: *The most significant barrier to services for youth with SED and their families is the fragmented nature of currently available funding streams.* Historically, Harris County public youth service agencies have had separate missions, overlapping services and individual "mental health" budgets. The lack of adequate insurance coverage and public mental health service capacity forces families to over-utilize the already burgeoning primary health care system. Those providers are inadequately equipped and/or trained to manage and provide for the needs of children with SED and their families. Other barriers include lack of adequate public transportation, and the past history of local public and private agencies working in "silos" with individual goals as opposed to collaborative goals.

5. Collaboration with Other Federal, State & Local Programs & Reform Initiatives:

Local Child Welfare Services Collaboration: While Child Protective Services in Texas is a state-managed program through the Texas Department of Family and Protective Services (DFPS), there has been a long tradition of county-level involvement. In 1966 Harris County Protective Services was formed in an agreement between Harris County Commissioners Court and DFPS. In a unique governmental collaboration, protective services for children and adults in Harris County are seamlessly provided by the state of Texas, acting through Texas Department of Family & Protective Services (DFPS), and Harris County through HCPS. HCPS provides direct services to children not served by DFPS through Community Youth Services (CYS), Chimney Rock Emergency Shelter and TRIAD Prevention Program.

TRIAD Agency Collaboration: In January, 1974, HCPS, Harris County Juvenile Probation Department (HCJPD), and the Mental Health Mental Retardation Authority (MHMRA) of Harris County submitted a proposal to Harris County Commissioners' Court for funding of new residential programs to care for local troubled children and youth. The Commissioners' Court placed funds in the MHMRA budget specifically for residential services to children and adolescents. The alliance between HCPS, HCJPD, and MHMRA became known as, **TRIAD**, a consortium of three county government agencies serving children working together to coordinate the public child care resources of Harris County.

As a result of TRIAD planning and program development efforts, the **TRIAD Prevention Program (TPP)** was initiated in 1998, and is administrated by HCPS. Using blended funding from the TRIAD agencies and other local and state funding, a variety of services are offered to at-risk youth through TRIAD Prevention Program, including:

Court services: Justice of the Peace (JP) Court Family Service Case Managers, located in 15 JP courts, provide coordination and referral services to youth convicted of misdemeanors per judges' orders; Truancy Learning Camp for truant youth and their families (partially funded by the Harris County Community Development Department); mental health and social service referrals.

Diversion services: Community Youth Development (CYD) Program funded by DFPS to support community-based youth development services; the Intake/Diversion Program works collaboratively with local law enforcement and HCJPD to provide screening, assessment, crisis intervention, short term counseling and information/referral services to Class C youth offenders to divert them from formally entering the juvenile justice system;

Mental Health Services: MHMRA contracts with TRIAD Prevention Program to oversee the TRIAD Mental Health Services Program, where MHMRA caseworkers provide short-term, intensive, home-based counseling and case management services to youth identified with SED and their families, allowing youth at risk of residential placement to remain in their homes.

TPP also administers the DFPS Services to At-Risk Students (STAR) prevention grant to provide in-home and school mental health services to at-risk youth. TRIAD Prevention Program collaborates with DePelchin Children's Center to provide short term home- and school-based mental health services to youth with SED and their families in the STAR Program.

Coordination for children with multi-agency needs: Since 1992 the TRIAD agencies have collaborated to administer and fund the state-mandated Community Resource Coordination Group (CRCG), the precursor to the Harris County Alliance for Children and Adults (our current system of care for children/youth and their families). The Alliance is funded by the TRIAD agencies and administered by the HCPS TRIAD Prevention Program. A fulltime Alliance coordinator provides referral coordination and initial screening. The Alliance is now a multi-agency collaborative that meets monthly to build community capacity to provide seamless service delivery for children with multi-agency needs, AND to provide recommendations for services and supports for referred children and adolescents with multi-agency needs who are at-risk of out-of-home placement due to SED and/or other disabilities. The TRIAD agencies provide the Alliance with a pool of county dollars to fund a limited number of residential placements & some flexible funds for wraparound.

State and Local System of Care Collaboration:

Harris County Alliance for Children and Families: *Though limited in scope*, the county has some experience in working collaboratively to develop a system of care approach for children/adolescents at risk of out of home placement due to severe emotional and/or behavioral problems. In May 2000, the Mental Health Association of Greater Houston (MHA) convened a group of local public and private providers of mental health services to children and adolescents and parent representatives to respond to a Request for Proposals from the Texas Health and Human Services Commission. The proposal called for an expansion of the Texas Integrated Funding Initiative (TIFI) by developing pilot projects for systems of care for these children/adolescents. The multi-agency group developed the Harris County Integrated Funding Initiative (HIFI) which was awarded \$75,000 from TIFI in FY 2000-01, and a \$60,000 grant for FY2001-2002 for the school-based pilot. MHA was the lead agency and MHMRA served as the fiscal agent. Family and agency representatives co-chaired committees and worked as a team to develop all aspects of the pilot project which served the Alief Independent School District's Alternative Education Center. Pooled funds for wraparound were contributed by several public agencies including HCPS, HCJPD, MHMRA and Texas Youth Commission (the state youth prison system). Since its merger with the Harris County CRCG to form the Alliance in 2003, the organization collaborates with other federal, state and local programs and reform initiatives. The Alliance will continue its collaboration in this new initiative by developing Memoranda of agreement, becoming knowledgeable about legislation needed to advance state and local systems of care, assisting family organizations in developing their advocacy capacity, and providing partners and community with training on all levels of system of care development and sustainability.

Juvenile Probation: For the past eleven (11) years HCJPD has worked with non-profit organizations, local school districts and other agencies to provide substance abuse education, intervention and prevention services, mental health diversionary needs programs for youth with mental health needs, crisis stabilization services for acute psychiatric needs and employment education and vocational training.

In 1998 HCJPD collaborated with the Houston Independent School District (HISD) to apply for Safe Schools Healthy Students Initiative funds. This collaboration involving more than 15 non-profit and community-based organizations and city & county agencies developed services to enhance safety and address mental and physical health issues in several schools.

In 2001, HCJPD and MHMRA received state funds to establish a specialized intensive supervision and treatment unit for juvenile offenders with mental illness designed to divert youth at risk of being removed from their homes to residential treatment facilities by providing intensive community-based probation and mental health services. TCOOMMI is in its third year of operation and during FY 2002 served 123 youth and their families.

HCJPD administers the county's Juvenile Accountability Block Grant (JAIBG) funds to provide individual, family and family group counseling to female offenders. The local vendor provides the girls and

their families with a unique culturally diverse communication skills development course provided in English and Spanish.

In 2001, HCJPD joined the Partners Alliance for Youth Strategies (PAYS), a partnership designed to address the vocational training and job readiness needs of youth and in particular Harris County at-risk and delinquent youth. The group applies for funds that meet the group's collective needs. In 2002, one partner was awarded a 3-year grant to implement the Youth Offender Demonstration Program.

Other Local Collaboratives:

The Harris County Community Access Collaborative is comprised of over 100 Harris County public and private safety net health systems, coalitions, advocacy groups and service providers who are working together to assist the approximately 800,000 uninsured and the additional 500,000 underinsured Harris County residents in receiving medical care at the most appropriate setting. The Collaborative is moving beyond their initial focus on the provision of primary care, and is now developing a Provider Health Network and the Harris County Medical Reserve Corps. **Gateway to Care**, the Collaborative's program arm, is a Community Access Program funded by the Health Resource and Services Administration. Gateway to Care is working with local communities in developing **Federally Qualified Health Centers**. **Reach Our Community's Kids (ROCK)** (Advisory Board for Gateway to Care) has parent and consumer involvement and represents the voice of children with SED and their families to the Coalition. Gateway to Care and ROCK will function as an integral part of the Alliance SOC expansion.

Harris County Joint City / County Commission on Children (City of Houston and Harris County): The mission of the Joint Commission on Children is to generate an action plan advocating for individuals below the age of eighteen and their interests; assess the general welfare of our youth; offer ways in which the key needs of these individuals can be met, and promote the healthy development of children. Actively involved in the planning of this proposal, the Commission will assist in planning, developing and marketing social change, especially in legislative reform issues. (See letter of commitment.) **The Mental Health Association of Greater Houston** is a non-profit United Way Agency dedicated to the promotion of mental health and improved care and treatment for persons with mental illness. The agency works with communities, legislators and major stakeholders to respond to local mental health needs through collaboration and coalition building on a city, county, state and national level. MHA was recently awarded a JET Foundation grant to develop a system of care for youth with SED in the juvenile justice system, and will be involved in various aspects of our SOC expansion including consulting with the Alliance legislative liaison re: state and national mental health legislative issues. **Family-Centered Child Care Collaborative (FC4)**, a program funded in 1998 by the Greater Houston Collaborative for Children is comprised of 11 community organizations that serve 87 local child care centers. A major goal of FC4 is to focus on the child as part of a family system. **ChildBuilders**, a member agency, contributes two parent education consultants to work with the centers in the areas of parent education and involvement. The Alliance Training Team will train Collaborative staff and service providers in mental health needs and services to children with SED, as well as systems of care principles and values. ChildBuilders is interested in providing advocacy services as outlined in their letter of commitment. **The Homeless Youth Network (HYN)** is a coalition of 10+ Harris County agencies serving runaway and homeless youth. The coalition seeks additional funding sources to provide street outreach, residential services (shelters, transitional living), mental health and primary health services. HCPS TRIAD Prevention Program and the HCPS Chimney Rock Center (CRC) Emergency Shelter are active network partners. **The Council of Agencies Serving Youth** is a collaboration between Harris County Community Youth Services (CYS) and IntraCare Hospital to provide in-service trainings and continuing education in mental health issues at no cost to a variety of service providers

SECTION B: IMPLEMENTATION PLAN (55 points):

The **Harris County Alliance for Children and Families** *envisions* a system of care for our children and youth with SED and their families that will 1) allow youth with SED to live at home, 2) attend school every day, 3) ensure the satisfactory completion of each child's developmental milestones, and 4) **transform** our mental health service delivery system. In order to achieve our *vision*, the Alliance proposes to adapt the **overarching goals** of the Child Mental Health Initiative (CMHI):

Goal 1: Expand Harris County, TX's capacity to serve children and adolescents with serious emotional disturbances and their families.

Objective 1.1: Diffuse use of wraparound model through the service area.

Objective 1.2: Utilize feedback to strengthen SOC at all levels

Objective 1.3: Create infrastructures capable of sustaining the SOC.

Objective 1.4: Reduce the cost per child served through the SOC.

Objective 1.5: Empower organizational change in support of SOC.

Goal 2: Provide a broad array of effective services, treatments, and supports by mapping Harris County's current capacity and resources, and growing this capacity to match our vision for the Alliance.

Objective 2.1: Enhance the ability of the SOC to deliver evidence-based/promising practices.

Objective 2.2: Improve mental health status of children and youth served through the SOC.

Goal 3: Create a care management team with an individualized service plan for each child based on their strengths, goals and choices.

Objective 3.1: Serve youth and families through a multi-disciplinary SOC that has relevance to each child and family.

Goal 4: Incorporate culturally and linguistically competent practices for serving all eligible Harris County children, youth and their families.

Objective 4.1: Case planning for children will be culturally and linguistically appropriate.

Objective 4.2: Children and Youth will be served by ethnically/linguistically appropriate evidence-based/promising practices.

Goal 5: Promote full participation of Harris County families and youth in all aspects of system of care and at all levels.

Objective 5.1: Family members serve as full partners at all levels of the SOC.

To achieve those goals, we will develop the following key administrative structures and procedures:

1. Infrastructure Development (15 points)

How will the infrastructure for the system of care be developed:

The Alliance Project Manager and Administrative Team members (Evaluation staff; various coordinators and a pool of Parent Partners) will be hired and trained in principles of SOC during the first few months of the project. We anticipate that the Alliance infrastructure will be developed in year 1, and that the SOC will begin to operate during Year 2. The Alliance will begin to enroll and serve children and their families through the Alliance Network of supports and services from years 2 through year 6. National Evaluation involvement will begin in year 1 and continue through year 6.

Composition and responsibilities of the Governing Board:

The Principal Investigator (Mr. George Ford, J.D., Executive Director, HCPS) will, with the assistance of the Administrative Team, family and community input, convene an Alliance Governing Board comprised of a cross-agency group of Harris County, City of Houston and State of Texas system administrators, policy makers, service providers, youth and family representatives, and community members. Many of these individuals are

directors of agencies that are current members of the Alliance and have working relationships with our efforts to develop a local system of care. Currently we have not been able to identify a significant pool of parents and youth to serve on the board. Therefore, Governing board members listed below will be asked to identify at least one parent representative and partner with them as governing board co-members. Members will have the authority to make policy decisions for the Alliance system of care, and to align plans, policies and procedures to accommodate the coordination and delivery of services within their agencies. They will also initiate and develop a sustainability plan to ensure our system of care will survive past the SAMHSA cooperative agreement.

Harris County Alliance Governing Board Composition:

- Harris County Protective Services for Children & Adults: Executive Director
- Harris County Juvenile Probation Department : Executive Director
- Mental Health and Mental Retardation Authority of Harris County: Executive Director
- Harris County Children's Assessment Center: Executive Director
- Harris County Attorney Judge Eckel's office: representative (Judge Eckels is the lead administrator for Harris County)
- Texas Education Association Region VI Director or representative
- Harris County Hospital District: Executive Director or representative
- City of Houston Health & Human Services: Executive Director
- Texas Department of Family and Protective Services (Houston Region): Regional Director
- Texas Department of Health and Human Services: Children's Mental Health Services Director
- Federation of Families/NAMI- Houston chapter parent representatives
- Baylor College of Medicine: Child Psychiatry Chief
- DePelchin Children Center - Executive Director

The Chair of the Alliance Governing Board will rotate among partnering agencies and family representatives. Alliance representatives will meet regularly (monthly) in the first year and meet quarterly thereafter.

Alliance Governing Board Responsibilities:

During Year 1, and throughout the cooperative agreement, the Alliance Board will:

- Develop and uphold ***Memoranda of Understanding (MOU)*** and other formal agreements between collaborating agencies, community groups, network providers and all relevant political subdivisions of the State of Texas
- Develop a ***theory of change or theory-based logic model*** to serve as the basis for developing the strategic plan. The logic model will describe the current capacity, resources available, activities that will drive SOC development, and the individual, service and system outcomes expected from the SOC (Hernandez & Hodges, 2003).
- Develop a ***strategic plan*** to implement the SOC throughout the 6 years of SAMHSA involvement. The plan will specify how activities will be developed and include a technical assistance plan outlining training activities, social marketing needs, local level evaluation, compatibility with state-level transformation and ***sustainability strategies***.
- Develop policies, procedures and practices that promote cultural and linguistic competencies of local staff, agencies and service providers and fidelity to SOC principles and values. (Stroul & Friedman, 1986).

- Manage the Alliance through review, approval and timely submission of budgets and reports as required by funders.

Procedures for systems development:

Systems Integration: The Alliance, under the leadership of the Governing Board, will conduct baseline assessments, organize and coordinate resources available through Federal, State, and local human service systems responsible for serving children and youth with SED and their families through **strategic planning, consolidation of funding streams and policy formation**. It will also ensure a single point of entry into a system of care for children/youth with multi-agency service needs and their families, minimizing duplication of services and inefficient utilization of limited resources.

Development of a formal relationship with State of Texas Mental Health Authority. The Texas Department of Health, which oversaw MHMR services throughout Texas, became part of the Department of State Health Services (DSHS) on September 1, 2004. Steven Schnee, Ph.D., Executive for the county MHMRA or his designee will work closely with DSHS to develop a Memorandum of Understanding with the Alliance Governing Board. Dr. Eduardo Sanchez, (DSHS Commissioner), or his representative **Mr. Frank Vega, Program Specialist of the DSHS Community Mental Health Services : Childrens Services Unit** will be asked to actively participate on the Alliance Board to strengthen communication, increase local input into state-wide policies regarding children's mental health needs and systems of care, and increase the likelihood of sustaining our system of care and providing the state with an effective and replicable system-of-care model. Components of the proposed Alliance system of care model such as Parent Partners, intensive community case management, treatment foster care and MultiSystemic Therapy (MST) are already included in the State of Texas MHMRA- mandated Resiliency and Disease Management (RDM) model for use with children/youth with SED served by all Texas MHMRAs. The RDM model is described in the goals of the ***State of Texas Community Mental Health Services Block Grant Plan*** (Public Law 102-321).

Replication of System-of-Care Plan: *Beginning in Year 1, the Alliance Board, staff, community partners and families and youth with SED will develop a plan outlining how our local SOC model can be replicated throughout Texas. We will use the State of Texas Health and Human Service Commission's *Feasibility Study Summary Finding for Community-Based Treatment Alternatives for Children with Severe Emotional Disturbance* (Community Ties of America, Inc., September 2004) to develop the plan. Our model incorporates the state-mandated Community Resource Coordination Group (CRCG) model, local TRIAD government agencies (child welfare, juvenile justice and MHMRA), a network of community-based services and supports, and parent/ youth voice, choice and participation.*

A phased and strategic approach will be developed through the Alliance Governing Board to replicate the Alliance model in other Texas counties during the 6-year cooperative agreement and after the years of federal funding. This model can be modified to fit various community needs and resources throughout Texas.

Interagency collaboration: The merger of the county's CRCG with the Harris County Integrated Funding Initiative (HIFI) forms the basis of the coordinating group for this project. Currently, the Alliance is comprised of a variety of child-serving community based agencies that deliver services and supports in mental health, child welfare, juvenile justice, education, primary health care, substance abuse treatment and prevention services, vocational services/rehabilitation. Parent representatives are an integral part of the Alliance; **currently a parent representative (Mrs. Barbara Sewell) is the Alliance Chairperson**. In Year 1 the Alliance Governing Board will develop *memoranda of agreement* with its current partners and expand to include other community child-serving groups/agencies to formalize the planning, provision and evaluation of our local array of services and supports, i.e., the Alliance Provider Network. Formal agreements will be noted in policy manuals, board minutes and other documents shared among the agencies. These documents will specify the roles of each agency in the system of care and specify each agency's financial or in-kind contribution, official

representation in the governing board, and participation in strategic planning, delivery of service, and evaluation.

Service Integration: The Harris County Alliance Resource Coordination Team (ARCT) is the service-level coordination and service delivery structure of our local system of care, and serves as the **POINT OF ENTRY into the Alliance SOC**. Families can be referred from many sources, including schools, youth service agencies, service providers, and self-referrals. Upon receiving a referral for services for a child/youth with SED who is multi-agency involved, the ARCT Coordinator will screen the referral. The Coordinator will request that a designated care coordinator or parent partner contact the family and complete a strengths-based assessment which will be presented with other child/family data to a team unique for each child and family, including a facilitator specifically trained in Family Conferencing and SOC, professional and non-professional helpers, caregivers and others important in the child's life. The individualized care team, guided by youth needs and family strengths, develop a *individualized service plan and safety plan with recommendations for services and supports, including wraparound*. **Parents then choose services and supports** from the proposed plans. Care teams will convene to periodically evaluate the service delivery plan and to adjust services as needed.

Wraparound process: If they choose to participate in wraparound, they will receive assistance from an Alliance care coordinator and/or parent partner to identify and connect with service providers and natural supports chosen by families and youth. The Alliance will use a "**no reject, no effect**" wraparound philosophy in serving children and adolescents with SED and their families in our community. The wraparound care coordination process decreases the risk of duplication of services by multiple providers, and increases identification and incorporation of all needed services and supports that will keep children and youth in their communities. Families choose the team members. Families are engaged in the wraparound process, crises are stabilized, and the discovery of strengths and culture of the family, youth and staff drives the individualized service plan. Ongoing family team meetings with formal and informal supports will guide the service plan and will change as necessary to reflect changes. The care coordinator will assist families in organizing and coordinating their goals, services and supports and will arrange for service delivery to eliminate duplication of efforts, especially when services are delivered through collaborating child-serving agencies. Services and supports are family centered and driven, and are culturally appropriate. A comprehensive individualized and strengths-based assessment of family / youth life domains begins the process, and goals are set by the family for each domain (Dennis, VanDenBerg, & Burchard, 1990). All team members adopt a "whatever it takes" commitment to assist the child and family attain their goals. Outcomes are measurable. Ongoing intensive training in the wraparound process is provided to family members, service providers and other community stakeholders.

Flexible funds: Vinson et al (2001) indicate that paraprofessional and support services (respite, behavioral aids, family support groups, parent aides, family advocacy, family support) were the services most requested by families, but were not Medicaid or insurance billable. The Alliance has a five year history of pooling flexible funds to purchase services and supports that are not covered by traditional funding streams. A flexible funding pool developed by the Alliance Governing Board from re-appropriated and/or partner contributed dollars will be used to purchase non-reimbursable service and support items to meet each child and family's needs. Care coordinators will be responsible for accessing these funds to augment traditional funding sources. We have purchased a wide variety of family supports that are non-reimbursable by State and Federal fund streams (family outings, tutoring services, eyeglasses, educational materials) with blended flex funds in efforts to strengthen the family and decrease risk of out of home placements. We hope to increase the amount of blended flexible funds provided by partners as they increase agency commitment to our local system of care

throughout the 6 years of the SAMHSA cooperative agreement. We will continue to solicit and manage blended flexible funds.

Care review: At the individual level, the Care Coordinator will be responsible for periodic review of the individual child/family service plan. Periodic review will allow for the adjustment of wraparound services needed and access other needed services as appropriate.

At the systemic level, in Year 1, the Alliance Administrative Team will develop an Alliance Care Review Committee (ACRC) consisting of parent and Alliance multi-agency representation and Evaluation Team members led by DePelchin Children Center's Research and Grants Management Department. The Evaluation Team will train Care Review Committee members and a pool of parent partners to gather systems and client data to assess how well services are delivered to youth with SED and their families, and to ensure continuous quality assurance of service delivery to individual children and their families. The Administrative Team and the Care Review Committee will develop policies and procedures for *care review teams* that will, beginning in Year 2, assess the extent to which our service systems adhere to the system of care philosophy at the practice level. Care review data will be gathered using *System of Care Practice Review* materials developed by the University of South Florida (Hernandez & Davis, 2004), and the Wraparound Fidelity Index (Burchard, 202). The ACRC will examine a random sample of individualized service plans, interview children, key family members, care coordinators and other caregivers such as juvenile probation officers involved in service delivery to gather and analyze qualitative evaluation data for continuous program/quality improvement. The care review teams and Alliance staff will monitor the type of partner and network provider services provided and their fidelity of implementation. Working with the National Evaluation, the Alliance Evaluation Team will analyze and assess data regarding the effectiveness of the project both as a whole and by component. Adjustments will be made as needed to improve system service delivery.

Access: Alliance has a "no wrong door" policy, and all referrals from community agencies and individuals are provided with a comprehensive assessment and multi-agency team review. The Alliance Resource Coordination Team (ARCT) will serve as a central *POINT OF ENTRY* through which families, providers, child-serving agencies, primary care providers and others can refer a child for comprehensive multi-agency assessment, culminating in the creation and delivery of an team review plan with recommendations and an array of service and support *choices for families*.

Beginning in Year 1 the Alliance Administrative Team will review Alliance eligibility criteria and strengthen current procedures to ensure access, efficiency and timeliness in service delivery at the child/family level and at the community level. Outreach to local interagency partners and other community child-serving groups/agencies will be ongoing; all Network providers and Alliance partners will receive mandatory training in systems of care and be involved in ongoing evaluations of their adherence to system of care principles. The Alliance will enhance consumer and public literacy through multi-media media campaigns in English and Spanish to help reduce stigma and enhance community awareness of the project.

Transportation is the most frequently mentioned access problem in many of the SOC sites evaluated by the National Evaluation (Vinson et al., 2001), and is a major concern in our county (third largest county in the U.S.). Beginning in Year 2 Alliance staffings will be held at Chimney Rock Center in Southwest Houston, a location that is accessible by car and bus lines. We will provide families with bus tokens and/or taxi fares as needed. The Alliance will pay mileage and stipends to parents attending Alliance meetings, trainings, and all parent partner activities. We will make every effort to ensure that services and supports are located within distances that make them accessible to families, and meeting/service delivery times are flexible enough to meet the needs and schedules of these families. Non-English speaking clients will be provided information and services in their preferred language.

Financing Approach: Based on the vision and a strategic plan developed by the Governing Board and Administrative Team in Year 1 and continuing throughout the project, the Alliance Governing Board will develop a variety of strategies to ensure our SOC sustainability beyond the 6-year Federal funding period. We will use the *Sustainability Planning Tool Kit* (SAMHSA, 2003) as our guide. Steps include:

- The Governing Board will request that the Administrative Team complete a Sustainability Self-Assessment to gather sustainability baseline data based on the development of a Sustained System of Care Vision.
- Harris County parent organizations will hold Community Planning sessions including children, youth and families, as well as other key stakeholders, to gather family and community input. Sessions will be held beginning in Year 1 using a relational world view model of strategic planning and a series of prompt questions originally developed by the National Indian Child Welfare Association and modified as a sustainability discussion tool for any SOC community across the country. (SMHMSA, 2003).
- Based on these findings, the Governing Board and Administrative Team will develop a *sustainability strategic plan to map and access all existing categorical service funds* which include, but are not limited to: Medicaid, Title IV-B & IV-E, State Child Health Insurance Program (SCHIP), IDEA education funds, juvenile justice grant & general revenue funds, TANF, other federal funds, and private insurance. The plan will include strategic financing strategies including redeployment of existing funds, embedding staff in various systems, and blending funds across agencies (based on Wraparound Milwaukee model). The Governing Board will have authority to make policy and to commit funds for non-traditional supports and services, personnel, and other administrative functions.
- The Alliance Governing Board and Administrative Team will collaborate with Texas Department of State Health Services: Mental Health Services and Alcohol & Drug Abuse Services, Department of Family & Protective Services, the Texas Health and Human Services Commission Medicaid, CHIP, TANF, HHS Program Policy departments, city and county health departments, Harris County Hospital District, Harris County Youth and Family Services agencies, community child-serving agencies, children's mental health providers, state legislators, child advocates, and family organizations to research and develop policies, procedures and funding sources that meet Harris County's needs and strengths.
- Local parent groups led by the Federation of Families Houston Chapter will advocate for increased SOC state and local funding, supports and services to the Texas Legislature.
- The Alliance will request training and technical assistance from SAMHSA and national SOC trainers regarding sustainability issues (including family and youth advocacy) that will impact our local capacity to continue past our six year agreement period.

Workforce development: For almost two decades many efficient and unique models for systems of care have been funded by the CMHS. *Of particular interest to the Alliance* are models for enhancing the capacity of current and future health provider systems and personnel to provide treatment and services through the systems of care model. One exemplary program is the Pitt-Edgecombe-Nash Public Academic Liaison (PEN-PAL) program which originated in 1994 with a four-year \$5 million federal grant to the Child and Family Services Section of the North Carolina Division of Mental Health. In addition to developing multi-agency teams of service providers, parents and community organizations to create a seamless system of care, they partnered with Eastern North Carolina University to provide training, resources and technical assistance for service providers and students enrolled in ECU health science programs. Professors from the psychology, education, nursing and counseling departments were involved in the PEN-PAL training component. Dr. Lenore Behar (Child & Family Section Services chief) expressed that it was important to *"get a university involved so rather than our spending years and years trying to retrain professionals, we're partnering*

with the university to change the way they teach students who will become professional service providers."

Beginning in Year 1 the Alliance clinical directors and staff will review and adapt curriculum developed by the Research and Training Center for Children's Mental Health at the University of South Florida (USF) that incorporates key concepts from SOC approaches into university curricula. The USF web-based access point for these resources will facilitate this process. The Alliance plans to use lessons learned and resources developed from PEN-PAL (now the Eastern North Carolina Public Academic Liaison, or ENC-PAL), USF and similar programs (Community Mental Health Program at Trinity College in Vermont, Training for Interprofessional Collaboration Project at the University of Washington in Seattle, and the clinical child psychology internship program at the University of New Mexico Health Sciences Center) to build a strong system of care training component using family as co-faculty, evidence-based curriculum, and state-of-the-art technology (interactive videoconferencing, Internet access) to impact **multi-level systems changes** in the field of mental health services for children and adolescents with SED and their families in our county. In Year 1 the Alliance will partner with Baylor College of Medicine to provide culturally competent, evidence-based training regarding systems of care for children and youth with SED and their families. (See letter of commitment.) Later expansion will include University of Houston Graduate School of Social Work, Texas Southern University, Texas Women's University school of nursing, and other local training institutes.

Support from community leaders: Beginning in Year 1 the Alliance Governing Board and Administrative Team will actively approach and inform community leaders of our local system of care, and will obtain endorsement of system of care goals and activities through MOUs. Community leader support has come from Texas Governor Rick Perry, Texas Department of State Health Services Commissioner Eduardo Sanchez, Harris County Judge Robert Eckels, Harris County Commissioners Court, City of Houston Mayor Bill White, City of Houston Director of Health and Human Services Steve Williams, DFPS Region 6 Director Randy Joiner, various clergy, business executives, university faculty and administrators, Joint City/County Commission for Children and Families, and leaders from racial and ethnic minority populations. (See letters of support.) Community leader endorsements over the next 6 years will include multimedia public statements, financial contributions and/or direct representation on the Board. The Marketing Coordinator will lead activities that regularly engage local leaders through outreach, training, social marketing and dissemination of information about the SOC philosophy and information, including results of Alliance evaluations. These efforts will further local support and sustainability of the Alliance beyond SAMHSA funding.

D. Plan for replication of the local SOC model in other communities of the state.

Fiscal integration into statewide policy initiatives: The Alliance is locally funded by the TRIAD county government agencies (HCPS, HCJPD, MHMRA) using Harris County General revenue dollars **AND** state MHMRA funds as designated under the State of Texas Mental Health Plan, with in-kind services such as advocacy, training, and parent partnering provided by other multi-agency Alliance partners and parent representatives. The 2005 Texas State Mental Health Block Grant Plan clearly endorses the system of care model, and has mandated elements of the system of care such as parent partners, intensive case management services, treatment foster care, Multi Systemic Therapy (MST) and other evidence-based practices and treatments to be adopted by community MHMRAs. As a result, the MHMRA of Harris County has adopted these policies and has begun to provide SOC identified services to children and youth with SED. The FY 2005 State Texas Mental Health block grant is approximately \$3 million, with \$500,000 set aside for special projects such as systems of care. The Alliance will work closely with state staff to access those funds to develop such evidence-based mental health services as therapeutic foster care and Multi-Systemic Therapy (MST) service delivery in Harris County.

The Texas Medicaid program pays for mental health services to income-eligible children and youth through the State Plan model, which requires that all Medicaid services are available to all Medicaid enrolled individuals statewide. HCPS, HCJPD and MHMRA are Medicaid providers, and all Alliance network service providers will be required to be Medicaid providers. Harris County participates in the TEXAS Medicaid STAR+PLUS managed care organization (MCO) and the Primary care case management (PCCM) plan. Also, providers will access Texas Children's Health Insurance Program (CHIP) funds to pay for inpatient and outpatient mental health services to children of low-income families that do not meet Medicaid income eligibility criteria.

Beginning in Year 1, the Alliance Administrative Team will develop a plan to ensure that Medicaid and CHIP benefits are obtained for all eligible children and their families that are referred for services. The Alliance will work closely with Texas Health and Human Services staff in developing Medicaid waivers that will re-appropriate residential funds into payment for community-based services and supports.

E. Strategies for developing the structures of a system of care:

Clinical Network: In April 2005 the Alliance members, family representatives and other community service providers updated the 2003 Alliance Comprehensive Community Survey to determine our local capacity for treatments and supports currently available to Harris County children/adolescents with SED. (See Appendix for clinical services and supports.) Although we found that Harris County has many traditional services and supports, we are still in need of community-based informal supports and evidence-based best practice interventions including, but not limited to, recreational services, mentoring, respite services, parent partners, MultiSystemic Therapy, and therapeutic foster care. In Year 1 and throughout the cooperative agreement, we will begin the development of ethnically specific provider networks by recruiting and training culturally and linguistically competent service providers and supports from the Asian, Hispanic and African American communities to provide services such as mentors, community aides, vocational supports, respite providers, and clinicians trained in evidence-based treatment practices such as intensive care management, therapeutic foster care, home-based crisis intervention, and MultiSystemic Therapy. In doing so we can ensure quality service and build a culturally diverse model that can be replicated with modification throughout the State of Texas.

John Sargent, M.D., Chief of Baylor College of Medicine Ben Taub Child Psychiatry Clinic, and Diana Quintana, Ph.D., Harris County Juvenile Probation Department Director of Psychological Services, will provide clinical leadership in the local implementation of professional practice standards and guidelines for the Alliance Clinical Network. They will review network service provider policies and procedures re: delivery of specific clinical interventions, and will address the delivery of services such as intensive care management, therapeutic foster care, and home-based crisis intervention. *In Year 1 we will contract for MST Train the Trainer services for selected participants who will then train staff within their agencies/organizations to provide MST therapeutic services beginning in Year 2.*

Administrative Team: In Year 1, after hiring key staff, the Alliance Program Manager and staff will assist the Governing Board in developing a vision and strategic plan (logic model) for social marketing, local-level evaluation and sustainability. **Many team members will be embedded in partnering agencies** such as MHMRA, HCJPD, Baylor College of Medicine, and DePelchin Children's Center. The Administrative Team will receive training and technical assistance from SAMHSA staff, as well as national leaders in the area of SOC. The Alliance Administrative team will develop and manage the budget, assist in integrating appropriate funding streams, award and manage contracts, use the results of the National Evaluation and other local evaluation to develop policies and practices, and develop a quality improvement plan. They will implement care review procedures; monitor individualized service plan implementation/outcomes; and monitor/comply with the Health Insurance Portability and Accountability Act (HIPAA).

Training Capacity: (See Workforce Development section) The Alliance acknowledges and supports the need for those involved to understand and value the meaning of **System of Care**. In Year 1 a full-time Training Coordinator will analyze the training and technical assistance needs, and develop a Training Plan based on provider, family and our community's input and needs. The Alliance will contract with nationally renowned trainers and consultants with specific expertise in SOC development and management. Over the next six years we will provide SOC training to future healthcare and social service professionals in local medical and nursing schools, undergraduate and graduate schools of social work and other local institutes of higher learning. In Year 1 the Alliance will develop a plan to recruit and hire natural supports within ethnically and culturally diverse neighborhoods. Also in Year 1 we will begin to collaborate with local universities such as **Texas Southern University (TSU), a traditionally black university**, to provide SOC training to undergraduate social work students. Upon graduation, many of these students are hired as child welfare and juvenile justice caseworkers, and often encounter families with multiple agency referrals for children with SED. The Alliance will work with TSU and University of Houston Graduate School of Social Work faculty to develop an SOC training for graduate students, and will actively recruit ethnically diverse and bilingual (African American, Asian and Hispanic) students to positions within the Alliance network of care.

Each of the major collaborators have their own training budgets and training plans which will serve as the springboard for the development of a collaborative approach in implementing the training strategies in the system of care approach. We will include parents, other caregivers and youth in training activities both as participants and trainers. Led by system of care principles and values of system-wide collaboration, we will seek and utilize cross-system training strategies, coordination of training resources, and maximize opportunities for interagency staff and children and families to teach each other.

Performance Standards: In Year 1 the Alliance Governing Board, the Administrative Team, Clinical Directors and Evaluation Team will work with SAMHSA technical assistance consultants and the National Evaluation team to develop local and national benchmarks which will measure the degree to which our system of care meets quality and effectiveness goals. We will define and measure **child and family outcomes** as well as **systems outcomes** using local and Government Performance and Results Act (GPRA) mandated performance targets. Baselines will be established through a community-wide assessment process which will identify strengths and gaps in the Alliance service system of formal and informal services and supports, as well as demographic information about youth and families to be served. All projects will comply with all regulations for the National Evaluation.

Management information system (MIS): A goal of systems of care is to create integrated, or at least compatible, MIS systems across child-serving agencies (Pires, 2003). Even though Harris County has a number of existing MISs that gather information on specific pools of clients served, this community lacks a fully integrated data management system. Each of the TRIAD agencies and DePelchin Children's Center has an MIS that can record, store and analyze the type, amount, and cost of services delivered to each child in the SOC. Tracking of services delivered by such funding streams as Medicaid and those covered by cooperative agreement funds and any other state or private funding streams is also available. We are aware of the need for an integrated MIS across collaborating agencies to coordinate service delivery, and integrate child and family outcome data from the National Evaluation in compliance with HIPAA specifications. During Year 1, an integrated MIS plan will be initiated. We will investigate web-based software that is HIPAA-compliant which allows all providers to remotely input data via Internet to the MHMRA database.

Office in the community: The TRIAD Prevention Program will be the administrative home for the Alliance and the Administrative Team which will be supervised by the TRIAD Prevention Program Director, Ms. Deborah Colby. The Administrative Team has offices throughout Harris County, including the Chimney Rock Center, DePelchin Children's Center, MHMRA offices, HCJPD, and Ben Taub General Hospital Child Psychiatry Clinic. These community offices are readily accessible by public transportation.

F. Plans to collaborate with other child servicing systems:

In Year 1 the Alliance Governing Board, assisted by the Administrative Team, will develop *memoranda of understanding* with the following local and/or state agencies to increase system of care development efforts:

Primary care system: Texas Department of State Health Services: Community Mental Health Services; Harris County Hospital District; Harris County Department of Health and Human Services; City of Houston Health and Human Services; Gateway to Care collaborative for local healthcare; Baylor College of Medicine; University of Texas Health Care System – Houston;

Juvenile justice: Harris County Juvenile Probation Department; Texas Youth Commission Texas Juvenile Probation Commission; Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) to address the establishment of a comprehensive continuity of care system that emphasizes public safety and treatment intervention for juveniles and adults with mental illness.

Child welfare: Texas Department of Family and Protective Services: state officials, Region 6 Director, Harris County Protective Services for Children and Adults board; Joint City/County Commission for Children; Healthy Families Initiative

Education: Harris County Department of Education, Harris County Independent School District, Texas Education Association (TEA): Region 4, 23 other local school districts.

The MOUs will specify planning, provision and evaluation of services to local children and youth with SED and their families involved with the Alliance system of care. The individual MOUs will specify the role that the agency plays in the Alliance SOC, and will include each agency's financial or in-kind contribution, official representation on the Governing Board, agreement for staff participation in system of care training, and participation in strategic planning, delivery of relevant services and evaluation.

G. Training, Technical assistance, and Social marketing strategies that will be used to support the development of the SOC:

Training and technical assistance: As noted throughout this proposal, training and technical support will play a large role in developing, maintaining and sustaining the infrastructure of the Alliance system of care. In Year 1, the Administrative Team will hire a full-time Training and Technical Assistance Coordinator who will provide leadership in assessing Harris County training needs and developing an ongoing training plan. The coordinator will **establish an interagency team** to assist in assessing, planning and implementing the Alliance training and technical assistance plan. In Year 1 Baylor College of Medicine clinical staff, Alliance administrative staff and local parents will develop a plan to provide system of care instruction to primary and mental health professionals in their training programs using system-of-care curriculum developed by the Research and Training Center for Children's Mental Health, University of South Florida Louis de la Parte Florida Mental Health Institute. Training will begin in Year 2 and continue throughout the program (See Baylor College of Medicine letter of support.)

Social Marketing: In Year 1 the Alliance will hire a .5FTE Social Marketing/Communications Coordinator who will provide leadership in developing and implementing a culturally and linguistically competent social marketing plan based on input from parents, parent advocates, youth and Alliance partners. The marketing plan will include strategies that provide multi-media public information of the Alliance system of care and its services, educate the public about children's mental health needs and good mental health practices, and support the Federation of Families – Houston Chapter and NAMI – Houston chapter to implement outreach strategies to Harris County families of children with SED. The Social Marketing/Communications Manager will assist in establishing partnerships with local child and family advocacy and service groups, organizations and local business to obtain funds, expertise, support and resources for the Alliance. This director will also serve as our liaison to the National Campaign. Alliance will receive technical assistance that is specific to our local needs and resources, distribute SOC community materials at local trainings, and develop a Harris County

Children's Mental Health Summit Day in collaboration with local families, service partners and community advocates.

H. Increased capacity and quality of services delivered to children with a SED.

Number# of children expected to be served annually in the SOC: Beginning in year 2 and continuing through Year 6 the Alliance will provide direct services to at least 150 children and youth with SED and their families per year (total N => 750).

Estimated number of children to be served yearly beginning in year 2 :

- care management: 100
- intensive home-based services: 75
- crisis intervention: 75
- day treatment: 25
- therapeutic foster care: 25
- respite care: 75

I. Participation in the development of the implementation plan contained in this application:

- Governor Rick Perry: support for grant submission
- Dave Wanser, Ph.D., Deputy Commissioner, Behavioral & Community Health Services, Department of State Health Services: Governor's letter of support
- George Ford, HCPS Director, Harvey Hetzel, HCJPD Director, and Steven Schnee, Ph.D., MHMRA of Harris County Director: MOU for TRIAD agencies
- Mr. Frank Vega, Program Specialist, DSHS Community Health Substance Abuse Unit: resource development information
- Sherri Hammack, Coordinator, Texas Integrated Funding Initiative Consortium, Office of Health Services Division: letter of support
- Jon Lindsay, Senate of the State of Texas: letter of support
- John E. Davis, Texas House of Representatives District 129: letter of support
- Tom DeLay, U.S. Congress House of Representatives: letter of support
- Pat Sibley, MHMRA of Harris County: conceptualization, resource development, technical support
- Miguel Anglada, LMSW, MHMRA of Harris County, Director Children's Services: conceptualization, resource development, technical support, proposal review
- Diana Quintana, Ph.D, Harris County Juvenile Probation Department, Deputy Director of Mental Health Services: conceptualization, resource development, technical support, proposal review
- Joel Levine, LMSW, Harris County Protective Services, Director of Administrative: conceptualization, resource development, technical support
- John Sargent, M.D., Baylor College of Medicine: conceptualization, resource development, technical support, proposal review
- Linda J. Courtney, Ph.D., HCPS and Kendall Mayfield, J.D., HCJPD: research, conceptualization, budgeting and grant submission
- Lane Coco, Ph.D., Jane Harding, Ph.D., and Jeannette Truxillo, Dr.P.H., DePelchin Children Center Research & Grants Management Dpt: conceptualization, evaluation plan design, editing.
- Steven Williams, Director of City of Houston Health & Human Services Dpt.: conceptualization, project plan design, and letter of support.
- The Council on Alcohol and Drugs Houston: research, resource development
- Grace Jennings, Ph.D., Houston Independent School District: Conceptualization, research, review
- Barbara Sewall, Federation of Families – Houston Chapter parent representative, and Chair of Harris County Alliance: conceptualization, insight, proposal review
- Rev. Steven Holloway, P.A.C.E. Youth Program: conceptualization, technical support
- Asian Counseling Center: research, technical support, conceptualization
- Helen Stagg, Families Under Urban and Social Attack (FUUSA): conceptualization, technical support

J. Extent to which nonfederal match dollars demonstrate interagency collaboration through contributions from different child-serving agencies:

The TRIAD governmental agencies (HCPS, HCJPD, and MHMRA) will provide in-kind contributions of existing county funds for salaries, fringe benefits, training resources, office space, administrative and infrastructure support to the Alliance. In addition, the residential dollars appropriated by the TRIAD agencies (general revenue county funds) to the Alliance will be evaluated and negotiations to re-appropriate dollars for residential care into wraparound funds will occur in Year 1. DePelchin Children's Center will contribute the use of its state-of-the-art training facilities, and various organizations serving African-American, Hispanic and Asian families will contribute staff time for Alliance cultural diversity trainings.

K. Letter of assurance from the Governor or the Governor's designee: see attachment.

2. SERVICE DELIVERY (25 points):

A. Specify criteria used to create efficient access into systems-of-care services, including:

Eligibility criteria:

Age	0-21
Diagnosis	Have emotional, behavioral, or mental disorder diagnosable under DSM-IV, ICD-9-CM or subsequent revisions. For children age 3 or younger with an SED, the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:03) will be used.
Disability	The level of functioning is such that the child or adolescent requires multi-agency intervention involving two or more child-serving agencies.
Duration	The disability must have been present for at least one year, or based on diagnosis, severity or multi-agency intervention, is expected to last more than one year.
Other	Youth with co-occurring substance use disorders, chronic medical conditions, mental retardation, and/or other mental health disorders are eligible for services. Are in eminent danger of out-of-home placement

Referral sources: To ensure there is "no wrong door" to our local system of care, Alliance will accept referrals from any child serving agency or provider including schools, community leaders, juvenile probation, justice/corrections, child protective services, mental health or chemical dependency providers, primary care providers, city/county health departments, parents, self, and others who have reason to be involved with the child and family.

Enrollment procedures: 1)The referring agency staff or parent will contact the Alliance Resource Coordinator to initiate the process. 2)The Resource Coordinator will gather pertinent information and screen the application for appropriateness with the referral source. 3)Family contact will be made immediately and an official case record started if the family chooses to receive services. 4)The Resource Coordinator will set an intake appointment to gather the initial information and assure that the individual child and family data/evaluation tools are collected. If an embedded Care Coordinator is the referral source, the Resource Coordinator will collaborate with the Care Coordinator to complete the intake process. 5)The Resource Coordinator will also gather information from the family regarding the development of the individualized care team, including a contract Family facilitator, the caregiver(s)/parents, youth (if over 10 years), Alliance partner agency staff with expertise in areas such as mental health, juvenile justice, social services, and educational services specific to the child's individual needs and other family/community supports the family invites to

review the child and family's needs, strengths and goals. 6) Care team members will be contacted and their participation in the family conferencing session will be solicited. 7) The family will give input as to the most convenient location for the Care Team conference and all participants will be notified of the date, place, and time. 8) Community and family members who have special transportation needs will be provided appropriate transportation to the Care Team Conference.

B. Service provision components:

Required mental health services & supports: Harris County children/youth with SED and their families have a wide range of services and supports to choose from in developing their individualized plans, as shown below:

Table 3: Required Mental Health Services and Supports

Service	Current Providers:
<i>Diagnostic and evaluation services</i>	UT Mental Sciences Institute; MHMRA; Harris County Hospital District (HCHD): Ben Taub Hospital, NeuroPsychiatric Center & Children's Psychiatric Clinic; DePelchin Children's Center (DCC); UT-Harris County Psychiatric Center (UT-HCPC); TRIAD Prevention Program;; HCPS Children's Crisis Care Center; HC Children's Assessment Center
<i>Case Management, including Intensive Case Management</i>	HCPS: Community Youth Services (CYS); MHMRA; Family Advocacy Case Management Services; Kinder Clinic; DCC; Houston Independent School District (HISD): West District Youth & Family Center; TRIAD Prevention; HC Alliance for Children & Families Resource Coordination Team (ARCT); HCJPD
<i>Individualized Service Planning</i>	HCPS: HIFI; Harris County ARCT; DCC; MHMRA; HCJPD
<i>Outpatient services – Individual, group and family counseling</i>	DCC; Alliance for Multicultural Services; AAMA; Beal & Associates; Catholic Charities; Center for Family Consultation; Houston-Galveston Institute; Asian American Family Counseling Center; Behavioral Health Consultants; Center for Counseling; Christian Family Counseling; Clinica de Consultar Familiar; Family Enrichment Clinic; Family Services; Harris School; Houston Center for Christian Counseling; Inner Wisdom Counseling Centers; Jewish Family Services; Montrose Counseling Center ; HCPC; Ben Taub Child Psych.Clinic; MHMRA; HISD: West District Center; TRIAD; CYS; HCJPD
<i>Medication-related services</i>	MHMRA; Bayou City Research; Ben Taub Psychiatric Clinic; UT at Galveston; DCC; Numerous private therapists/psychiatrists ; UT-HCPC; HC Hospital District; HCJPD
<i>Emergency services, including crisis outreach and crisis intervention</i>	Ben Taub Hospital Neuro-Psychiatric Center; MHMRA CAPES; CYS; TRIAD Prevention Services; HCPC ; HCDC; DCC; HISD: West District Center;
<i>Crisis Stabilization and In-patient services</i>	Mobile crisis teams; MHMRA; Houston Police Dept.; HCPC; West Oaks Hospital; IntraCare Hospital; Cypress Creek Hospital; Devereux Residential; UT-HCPC; HCJPD
<i>Intensive in-home services</i>	DCC; Juvenile Probation: Youth Advocate Program; TCOMI; STAR Program of TRIAD Prevention; MHMRA Choices
<i>Intensive Day Treatment</i>	Child Development Center; Cypress Creek; IntraCare; West Oaks; Shiloh; Providence Day Treatment; Inner Wisdom Counseling Centers; Devereux Treatment Network; MHMRA New Day Program
<i>Partial Hospitalization</i>	Cypress Creek; Devereux; IntraCare
<i>Respite and Therapeutic Foster Care</i>	Mentor Inc., Trinity Foster Home; Unity Childrens Home; Initiatives for Children; Arrow Project; Deblin Health Concepts; DCC;
<i>Therapeutic Group Home services</i>	DCC; Houston Achievement Place; Jamie House; Nikkis Children's Home; AWARE
<i>Transition Services</i>	Covenant House; Texas Mentor; Texas Rehabilitation Commission; 23 school districts; DCC

In Year 1 we will participate in technical assistance and training opportunities offered by CCMHS and use evidence-based findings from the National Evaluation to identify service and support gaps, make adjustments to the informal and formal provider network, and implement Federal or professional practice standards and guidelines for service delivery.

Optional services: Optional services will be developed in response to the individual and collective needs of Harris County children with SED and families by the Alliance Resource Coordination Team(ARCT). The Alliance Resource Coordination Team is the gateway to our local system of care, and provides screening,

assessments, supports and services such as identification of funding sources to purchase services and supports. Family and community training for staff, families, and multi-agency personnel will be individualized to meet our unique community needs. The ARCT will identify and seek funding sources to purchase services and supports as needed.

Non-mental health services: Formal and informal support services are needed to promote the healthy development and well-being of youth and families served. Beginning in Year 1 the Alliance Administrative team will identify existing providers of such services, including educational services, health services, substance abuse treatment and prevention, life skills for adolescents, vocational counseling and rehabilitation, protection and advocacy and public awareness. Service gaps will be identified and potential service providers will be identified from among the collaborative partners and/or outreach to other organizations/agencies will assist in developing a full array of non-mental health services.

Substance abuse treatment services for adolescents with co-occurring SED: Assessing and treating co-occurring disorders is a critical piece in treating many youth with SED by the Alliance Resource Coordination Team (ARCT). The Council on Alcohol and Drugs Houston will provide assessments, counseling, community education and referrals for residential treatment and ongoing treatment for co-occurring disorders. These services are free of charge and are community-based. The Council will also provide information to Alliance SED youth groups and individual youth, parent organizations and Alliance service providers regarding substance abuse issues for identified youth and populations. Co-occurring post-traumatic stress disorders as a result of exposure to trauma (sexual, physical and/or emotional abuse) is common in this population as well. DePelchin Children's Center in Houston recently received a SAMHSA grant to provide treatment and community educational training on post-traumatic stress disorder (PTSD) and will work closely with the Alliance to provide all identified individual, group, family and training needs.

Substance abuse prevention interventions for pre-adolescents with SED: In collaboration with The Council on Alcohol and Drugs Houston, a Youth Coordinator will receive training in substance abuse prevention education and provide education to youth groups, parent organization groups, and formal Alliance trainings. The Alliance and parent organizations will work with the Texas Department of Health Services: Alcohol & Drug Abuse Services (TCADA) to advocate for increased substance abuse education services to Texas youth and families.

Co-occurring post-traumatic stress disorders as a result of exposure to trauma (sexual, physical and/or emotional abuse) is common in this population as well. DePelchin Children's Center is designated as a SAMHSA-funded Level III Center with the National Child Traumatic Stress Network and will provide trauma-informed treatment as well as community training on trauma related issues. Alliance partners will be invited to join the Community Networking meetings to further the dissemination of trauma-focused information.

Medical services for children with a co-occurring SED and chronic illness: Harris County and City of Houston medical departments, as well as Harris County Hospital District clinics and federally qualified health clinics throughout our community will provide medical services to identified youth and families without private insurance coverage. Funding for these services will be a combination of Medicaid and CHIP for eligible youth and their families.

Literacy interventions specific for children with SED: Literacy services are in place through Harris County's 24 independent school districts' special education service departments, including services geared to the individual needs of each child through use of IDEA and No Child Left Behind policies. Services provided through IDEA include, but are not limited to, vocational counseling, rehabilitation and transition services for children ages 14+. Beginning in Year 2, special education services will be provided at no cost to the family, and specially trained Alliance parent partners will be available to families to assist in obtaining needed educational services.

C. Describe the strategies to implement key service activities including:

Delivery of Clinical interventions: Two Clinical Directors (Drs. Sargeant and Quintana) will develop and direct the Alliance clinical network/system for children and youth with SED based on principles and values of system of care philosophy. They will select evidence-based practices such as MST and therapeutic foster care, and develop clinical assessments using strength-based, culturally and linguistically appropriate instruments. Clinical interventions will be delivered through the community based Alliance Provider Network using designated intervention protocol. All network providers will sign MOAs agreeing to provide clinical services using SOC-based practices and values, and attend mandatory SOC training. The Clinical Directors, along with parents and providers, will review and select culturally and linguistically appropriate standardized clinical assessment instruments and *practices* that recognize gender and cultural differences in the diagnosis of overt behaviors and the evaluation of presenting problems. In Year 1 a pool of local Alliance network service providers will receive Multi-systemic Therapy certification and Train the Trainer instruction. Upon completion, they will be able to train other local service providers to increase our pool of qualified MST providers.

Care management services: All families referred to the Alliance for services will have the opportunity to receive individualized care coordination/ management by an Alliance Care Coordinator and/or Parent Partner. Care coordination is an essential element of any system of care service delivery system and will be the responsibility of the designated Care Coordinator in collaboration with the Parent Partner. Families choosing not to participate in the full wraparound service component and only choose selected services will continue to receive care management from the Care Coordinator. Care Coordinators will be able to access flex funds and network providers and care coordination will be at a less intense level. The Alliance Care Coordinator and/or Parent Partner will coordinate services, establish eligibility for financial assistance and services under Federal, state and local programs, and document receipt of services. Care Coordinators will control some flexible dollars to authorize wraparound supports, and are responsible for leading ongoing care-planning teams. The ratio of Care Coordinator to client will be no more than 1:10 for children with intensive needs, and no more than 1:15 for children with intermediate needs. All cases will be followed for at least three years and will become part of the client/family level evaluation.

In the last two months of Year 1, the Alliance will hire and train seven (7) Care Coordinators, five (5) Parent Partners and a Coordinator Supervisor who will be embedded in each of the TRIAD agencies (HCPS, HCJPD, MHMRA) and DePelchin Children's Center. MHMRA already has two full-time Parent Partners and they will participate in the Alliance care team activities beginning in Year 2. Care management staff will work within the agencies and will be referred and/or identify children with SED who are involved in multi-agency services and are in eminent danger of out of home placement. One fulltime Care Coordinator supervisor will support a united (across agencies) care coordination approach even though multiple systems are involved. Training for Care Coordinators and Parent Partners (persons who have been primary caregivers for children with SED) in systems of care philosophy, wraparound processes and Teambuilding will be provided beginning in Year 1.

Individualized service plans: Beginning in Year 2 families and youth will work with their Care Coordinator, Parent Partner, interagency representatives and other family-identified formal and informal supports of their choice to form *individualized care teams*. Each family care team will use a standardized Individualized Service Plan (ISP) form developed in Year 1 by the Alliance Administrative Team. Using the *Family Conferencing model*, family and youth will provide input into their service and support needs that will assure safety, permanency, and remediation of issues/barriers to service access. Based on this information, the Care Team will develop a *safety plan and service plan* to meet these youth-guided and family-driven goals in ways that are culturally and linguistically appropriate for the family. In addition to "traditional" mental health services, the ISP will always contain an array of non-mental health culturally and linguistically diverse services and supports of the family's choice, such as respite providers, mentors, tutors, and other supports as identified by families. All roles and tasks will be specified in the ISP, including the agency responsible for care

coordination and ongoing review and revisions to the plan. Families make final choices on services and supports developed by the individualized care team.

Parent Partners will be recruited from culturally, linguistically and ethnically diverse groups representative of local families, and will serve as advocates for and assist families with services access. We will work with organizations such as the Asian Counseling Center, Families Under Urban Attack (FUUSA: serves a majority of African American clients), and AAMA (serves a majority of Hispanic non-English speaking clients) to recruit these and natural support providers. Parent Partners will attend Individualized Education Planning (IEP) meetings and assist in obtaining all relevant IDEA-related services and supports through their school district. These will be integrated into the ISP. For children in foster care or in danger of removal from their home due to abuse and/or neglect, the Resource Coordinator, at intake, will involve the DFPS caseworker to seek their input into the Care Team and coordinate all Title IV-B services available to the child and family within the ISP. The Care Coordinator will ensure that the Care Team remains aware of progress made toward goals and objectives in the ISP. The Care Coordinator will assist the Care Team in reassessing the goals and needs of the child and family at least quarterly, and will modify the ISPs accordingly. Duplication of services will be greatly minimized due to coordination by one entity. Each case will be reviewed quarterly by the Coordinator Supervisor to ensure appropriate client care and utilization of resources. In cases where additional resources are needed or there is a need for more intensive service or there is a deterioration in functioning of the child or family jeopardizing safety or permanency, another Care Team conference can be convened. The Coordinator Supervisor will assist the Care Coordinator and with consultation from either Clinical Director a new ISP may be developed.

D. Describe Family-driven care: Family-driven means families have a decision making role in the care of their own children as well as the policies and procedures governing care for all children in the community, state, and nation. This includes choosing supports, services and providers; setting goals; designing and implementing programs; monitoring outcomes; and determining the effectiveness of all efforts to promote the mental health of children and youth. Consumer-driven services are growing in strength and complexity and have true potential for transforming the mental health system nationally and locally.

In Harris County, the Houston Metropolitan Chapter of the Federation for Families for Children's Mental Health has worked for more than 15 years with parents, caregivers, legislators, public and private agencies and interested citizens to improve the systems of care for children with SED. **Mrs. Barbara Sewell is the local Federation Executive Director and serves as the Alliance Chairperson.** Also, NAMI Metropolitan Houston with 6 local NAMI affiliates in the Houston/Harris County area has provided advocacy and training in issues related to children's mental health. NAMI also has an anti-stigma campaign at the local level, and will partner with the Alliance to provide public information during Children's Mental Health Awareness Week (see letters of support). The Alliance will partner with these parent agencies to develop parent support groups throughout Harris County; parent education will be provided using "Visions for Tomorrow" education courses, taught by trained family members. Family partnerships will occur by recruiting and sustaining individual family members and family organizations to become involved in both Service Delivery and Infrastructure levels (Alliance Governing Board, Administrative Team, Alliance Resource Coordination Team, and Evaluation Team). The following are some methods we plan to incorporate into our system of care in Year 1 and through year 6:

- In Year 1 hire a full-time **Family Coordinator** as the key family contact for our local SOC. She/he will provide advocacy for family members of children receiving services, outreach to family members of children not receiving services, and serve as one of the family member representatives on the governance board. The Family Coordinator will work closely with the Federation of Families – Houston chapter and NAMI – Houston chapter, as well as state and national parent organizations to develop parent support groups throughout Harris County. The coordinator will develop a Family Team

of at least 10 trained parents, including Parent Partners. They will ensure that family voice and choice are present in individualized service plan development, system management (Resource Coordination Team and Board of Directors membership and meaningful representation), legislative lobbying and testimony, all evaluation activities, service delivery (i.e., volunteer and paid parent partners, TCOOMI group leaders) and training activities. We will solicit family representation to represent our local cultural/ethnic socioeconomic diversity.

- Individual families will participate in all aspects of the planning and delivery of services to their own children (family-centered) via the **individualized care plan**. The family has final decision and service delivery choice.
- The Alliance will provide parent stipends for meeting attendance and transportation expenses, payment for involvement in all aspects of evaluation and training activities, and child care to allow parents/family to attend meetings and trainings and parent partner activities.

E. Describe Youth Guided care: We encourage youth participation in all levels of the Alliance system of care. Therefore, in Year 1 the Alliance will hire two half-time Youth Coordinators (25 or younger) familiar with issues pertaining to children and youth with SED and their families to support active youth participation. We hope to recruit two graduate students in behavioral/social sciences from ethnically and culturally diverse populations, with one being bilingual in Spanish. The Youth Coordinators will assist in organizing recreational and skill building groups for local youth with SED who are receiving services, reach out to eligible youth who are not receiving services, and represent youth on the Alliance Governing Board and all other local, state and national functions pertaining to youth with SOC. Youth will be asked to participate in focus groups, evaluation of services, and provide feedback and recommendations re: services and supports. Beginning in Year 2 the Youth Coordinators will form social/recreational groups to encourage positive youth development, and assist older youth with SED in making a smooth transition from children's services to adult services. In Year 2 a Youth Advisory Board will be formed from local youth with SED who have been involved in child welfare, juvenile justice and/or mental health systems. They will be trained to work with incoming youth with similar experiences and provide peer support and advocacy services.

F. Explain how cultural and linguistic competence will be addressed within the SOC:

We adhere to Terry Cross's (1988) definition of a *cultural competence continuum as an ongoing developmental process during which organizations and individuals are continually challenged to do more*. Therefore, under the leadership of the Alliance Program Manager, the Alliance will:

- Year 1: Conduct a cultural and linguistic competence self-assessment of Alliance and service providers using National Center for Cultural Competence guidelines and *Checklists* (2003). Based on these findings, a formal plan can be established to direct organizational and staff training needs, policy formation and system TRANSFORMATION;
- Year 1 and ongoing: develop and maintain a **Cultural/Linguistic Competence Committee** (members to be selected from the community and representative of Harris County's cultural, ethnic, linguistic diversity). The committee will examine the Culturally and Linguistically Appropriate Standards in Health Care (CLAS), Title VI of the Civil Rights Act, and CMHS Cultural Competence Standards and provide the Alliance Administrative staff, Governing Board and service providers with pertinent information to include in policy and procedure manuals, and service provider MOAs. They will also review evidence-based practices and interventions, and provide recommendations regarding their use in various diverse populations. The Committee will meet at least monthly during Year 1 and continue meeting throughout the project to research best practices in cultural/linguistic competence, receive training from SAMHSA contractors and trainers, and provide findings and recommendations to

the Board regarding policies, procedures and community resource regarding cultural/linguistic competency.

- Year 1 and ongoing: The Alliance Training staff will coordinate mandatory system of care training, including cultural/linguistic competency, to all service providers, community partners, Alliance staff and Governing Board.
- Ongoing: Care coordination staff, Family Team staff, and community organizations will solicit family feedback regarding the cultural competence of their providers using the System of Care Practice Review (SOCPR) created by the Louis de la Parte Florida Mental Health Institute.
- Year 2 and ongoing: Care Coordinators and Parent Partners will assure that the individualized service plan is consistent with the cultural context of the family and will encourage families to use natural supports available in their communities.
- The Alliance Program Manager will enhance meaningful participation and advocacy from Harris County culturally and linguistically diverse groups representatives by ensuring their inclusion as members of the Alliance Governing Board, Administrative and Evaluation teams, care review groups and individualized care teams. The Administrative Team will review the service network every 6 months to ensure it includes providers representing the cultural and linguistic diversity of the community, and will actively solicit such providers to join the provider network.

3. Sustainability/Linkages with Statewide Transformation Efforts and Other Relevant Federally-Funded Programs (15 points):

The Alliance goals and objectives link directly with the overarching goals of the SAMHSA Child Mental Health Initiative and the Texas Department of State Health Services (DSHS) Children's Mental Health Services vision and values. Texas received a total of \$223,615,702 in SAMHSA funds in FY 2004-05, including \$32,486,643 in Community Mental Health Services (CMHS) Block Grant funds. We have communicated with Mr. Frank Vega, Program Specialist of the DSHS Community Health Substance Abuse Unit re: support of our application. He informed us that DSHS wishes to promote and expand systems of care for Texas children/youth with SED and their families. Contingent upon SAMHSA funding, the Alliance will be eligible to receive State CMHS Block Grant funds to provide evidence-based treatments such as therapeutic foster care, intensive case management, and MultiSystemic Therapy. The Alliance Project Manager will work closely with the Principal Investigator and Governing Board to develop procedures in obtaining state CMHS funds beginning in Year 1 and continuing past the six-year collaborative agreement.

Nonfederal match contributions: The Harris County TRIAD agencies (HCPS, HCJPD and MHMRA) have pledged in-kind support through staffing, equipment and facilities, service provision and access to current programs. Service providers such as Baylor College of Medicine, ChildBuilders and DePelchin Children's Center have also pledged support and contributions (see letters of support). These in-kind matches, and willingness to participate in interagency collaboration, are representative of Harris County's commitment to expand and sustain our current system of care for children and adolescents with SED and their families. (See Memoranda of Agreement and budget forms) We anticipate that matching funds will grow over the next six years, and the TRIAD agencies will assume all care coordinator and parent partner costs for staff embedded in their agencies by the end of Year 6.

In Year 1 the Alliance Governing Board will develop a *sustainability plan* that includes: mandate providers' access of Medicaid, state CHIP and other public/private insurance dollars; reappropriation of a portion of current TRIAD residential treatment to flex funds for nontraditional services and supports; collaborate with Harris County agencies that receive other federally funded initiatives such as Mental Health Block Grant Program, Safe Schools, Health Students Program, Child and Adolescent Mental Health and Substance Abuse State Infrastructure Grants, etc.) Training in sustainability of systems of care will be

provided throughout the six years to the Board, staff, families and community partners to enhance our ability to sustain the Alliance.

Section C: Project Management and Staffing Plan (15 points)

A. Brief description of applicant organization and relationship to other child- and family-serving organizations: Harris County is the applicant for these funds, and Judge Robert Eckels has designated management of the project to **Harris County Protective Services for Children and Adults (HCPS) TRIAD Prevention Program**. Basic protective services for children are facilitated through Texas Department of Protective and Family Services (DFPS) and include investigating reports of alleged abuse and neglect, promoting the concept of safety and stability within the family structure, and providing permanent placements for those who can not safely remain with their own family. HCPS is a county agency which provides 1) ancillary services for children not served by the DFPS and 2) supplements and enhances the services provided by DFPS. This unique county-state structure has permitted Harris County to provide comprehensive seamless services to its children in need since 1966. The HCPS Fiscal Year 2005-06 budget is \$18,666,657. HCPS employs 332 staff, and operates the following programs and services: Community Youth Services; CRC Emergency Shelter; TRIAD Prevention Program; BE a Resource for CPS Kids (BEAR); Children's Crisis Care Center; Region 6 Training Institute; Harris County Protective Services Clinic; and, Guardianship Program.

Relationship with Other Child-Serving Agencies and Organizations. HCPS is one of the three county TRIAD agencies (HCPS, HCJPD, MHMRA) that coordinate services for youth with multi-agency needs and who are at risk of out-of-home placement. TRIAD operates under a Memorandum of Understanding that has been in place since 1974. HCPS (with the approval and joint funding of HCJPD and MHMRA) administers the TRIAD Prevention Program, which demonstrates how successful integrated funding and management can effectively address the complex needs of children and families. **HCPS TRIAD Prevention Program administers the Alliance** which functions as the Harris County system of care service delivery agent. Alliance membership includes many local public and private child-serving agency representatives and family members. See HCPS and Alliance organizational charts in Appendix 6, and memoranda of understanding with collaborating agencies and organizations in Appendix I.

B. The Qualifications and experience of required personnel, including:

Principal Investigator: Mr. George Ford, HCPS Executive Director, will be the Principal Investigator for the Alliance. He participates in the Harris County TRIAD agency executive committee.

Mr. Ford is a licensed attorney and Licensed Master Social Worker-Advanced Practitioner with more than 30 years of experience in the fields of child welfare, advocacy and social services. Currently, Mr. Ford oversees more than 300 employees and a \$17+ million dollar budget. His employment experience includes Chair of the Harris County Youth and Family Services Division, advisory board member of Child Advocates, Inc., advisory committee member to the Child Welfare League of America's Executive Director and member of the Accreditation of Services for Families and Children, Inc. See Section G for CV.

TRIAD Program Director: See Section G for CV.

Alliance Project Director (Manager) : To be hired; qualifications included in Section G.

Key evaluation staff: Jeannette Truxillo, Dr.PH, is employed by DePelchin Children's Center Research and Grants Management Department. Dr. Truxillo has a Doctoral degree in Public Health from the University of Texas, School of Public Health. She has over ten years experience in the Behavioral Sciences that include directing and conducting a wide range of evaluations of federal, state and locally funded projects at DCC as well as in the community. She has presented at national, state, and special interest conferences over the years on community collaboration, family support models and children's mental health. In particular an overview of her dissertation was presented at the 17th Annual Research Conference: A system of care for children's

mental health, in Tampa, FL. She is currently supervising the evaluation for a replication of a child neglect prevention program that involves data and cost sharing on a national level funded by the Children's Bureau. See Section G for CV.

Family Coordinator : To be hired; qualifications included in Section G.

Youth Coordinators : To be hired; qualifications included in Section G.

Training & Technical Assistance Coordinator : To be hired; qualifications included in Section G.

Social Marketing Coordinator: To be hired; qualifications included in Section G.

Alliance Clinical Directors: John Sargent, M.D., and Diana Quintana, Ph.D., will serve as part-time Clinical Directors of the Alliance service provider network. They will participate in the development the strategic plan, identify evidence-based and promising practice treatment methods, services and supports, and work with national and local evaluators to develop performance standards. They will develop guidelines for specific clinical interventions and the delivery of systems-of-care services, will identify interdisciplinary training curricula and will implement training initiatives for caregivers, mental and medical health professionals, partners and future practitioners. See Section G for CVs.

State and local agency liaison: ChildBuilders will dedicate .25FTE staff to this effort. ChildBuilders has more than 30 years' experience in children's mental health advocacy and is well known to State and national representatives and senators as a strong advocate for children. In addition, ChildBuilders has strong ties with local child service agencies and organizations.

Key consultants: See Evaluation key staff above.

NOTE: A rationale for percentage of time each person will dedicate to the project is included in Section G: Job Descriptions.

He will be responsible to the Harris County community for addressing the needs identified in the cooperative agreement proposal and the strategic plan. In addition, Mr. Ford will be responsible for the fiscal and administrative oversight of the cooperative working agreement and will serve as a liaison between State officials and agencies. He will supervise the TRIAD Program Director and work closely with the Alliance Governing Board to create the Alliance vision and logic model in year 1.

C. Staffing Pattern Chart and combined Management Plan/Activities Timeline Chart : A staffing pattern/management chart has been included in Appendix 6.

D. Description of facilities, equipment, and resources: The Principal Investigator and his administrative staff (legal, fiscal management, human resources, etc.) will be housed at the HCPS administrative building (2525 Murworth, Houston, TX). The building is located near several thoroughfares and accessible by public transportation. This office houses several programs for neglected and abused youth and is near one of the Harris County Juvenile Probation Department's (HCJPD) satellite offices and its alternative education program. It is also within minutes of the Texas Medical Center, which will be a focal point for training and intervention initiatives. This location also houses the Regional Training Institute.

Other key personnel will be embedded within HCJPD, MHMRA and DePelchin Children's Center facilities located throughout Harris County in order to improve family access to administrative staff, program services, and other resources. All buildings are accessible by main thoroughfares and public transportation. The Clinical Directors will be housed at their respective primary employment locations. Dr. Sargent will have office spaces, equipment and supplies at the Baylor College of Medicine and Ben Taub Hospital. Dr. Quintana will have office space and equipment at HCJPD detention center.

DePelchin Children's Center Research and Grants Management staff will lead the evaluation function. The Evaluation Coordinator, Outcome and Process Evaluators and Research Technician will be officed at the DCC main campus with access to equipment and phone/ computer networks. The onsite Lead doctoral level DCC evaluator and parent partner will be officed with Alliance Administrative staff at the Chimney Rock Center

facility and have access to various management information systems. ChildBuilders is the State and Local Liaison for the collaborative and will provide office space and equipment as an in-kind match.

E. Service Delivery, ADA Compliance, and Cultural Concerns: All facilities and equipment used in support of this project will be compliant with the requirements of the Americans with Disabilities Act (ADA). The Alliance and all service providers (as a condition of participation in the Alliance provider network) will make reasonable accommodations for disabled participants and partners to participate in the governmental process or receive services. Postings concerning special accommodations due to disabilities and contact information will be placed in a conspicuous location for the public to view. Beginning in Year 1 the Alliance strategic plan will address cultural competency issues and will mandate that all providers, staff and board / committee members receive SOC training, including issues regarding cultural and linguistic competence to encourage competencies. Beginning in Year 1 African-American, Asian, and Hispanic organizations will be recruited to participate in policy development and service/support provision to ensure that culturally/linguistically competent services are available to diverse Harris County families.

F. Confidentiality Requirements: Due to the nature of services and supports provided by all Alliance partners, confidentiality is of primary concern. Both state and federal law mandate confidentiality in reference to children's mental health, medical, juvenile justice, and child welfare records. Each agency limits access to protected information and provides passwords for access to necessary information to critical staff. All participating agencies and contracted vendors will sign a certification of agreement to comply with all local, state, and federal laws and compliance. All practitioners must adhere to professional standards. Applicable staff and vendors are also *required via contract* to comply with the Health Insurance Portability and Accountability Act (HIPPA). Services will be provided in a confidential manner. Governing Board members, partners, staff, and service providers will be trained in systems of care and confidentiality issues will be addressed. In addition, youth and parents will be informed of their rights as a participant of the program and will sign releases in order to conduct evaluations and share Protected Health Information. Reimbursement through electronic transmission and all other services will be provided in compliance with the standard code of ethics for human service professionals and in strict compliance with all appropriate confidentiality laws.

SECTION D: EVALUATION PLAN (15 points)

A. Evaluation activities and procedures that will ensure successful implementation of the National Evaluation of the Comprehensive Community Mental Health Services Program

DePelchin Children's Center Research and Development Department will provide leadership in all evaluation activities and procedures for the Alliance. As reflected in the proposed goals and objectives above, the evaluation will assess the implementation, development, sustainability and effectiveness of the SOC. It will assess changes at all system levels - in the community system's infrastructure and capacity to sustain; in organizational structures and operations; in individual providers' expertise; and in child and family outcomes and perceptions. The Alliance will comply with all requirements of the National Evaluation and participate in the collection of descriptive and outcome data. The Alliance agrees to participate in the development and implementation of quality improvement methods and to work with the Project Officer and other contractors to identify benchmarks (goals) that will determine project progress such as, movement towards a family driven system of care, reduction of ethnic, racial and geographic disparities in care, AND improvements in functional behaviors. **Activities:** During the planning year, the Evaluation Team will collaborate with the Alliance and the National Evaluation to: (1) fully develop the evaluation design and logic model; (2) conduct the initial system of care assessment (infrastructure and service delivery); (3) abstract data from the records of the comparison cohort and obtain information regarding current status (4) design/ modify/ secure process and outcome evaluation tools; (5) design databases; (6) monitor the planning stage to assess the extent to which planning

activities follow the proposed planning steps, unexpected occurrences, the extent to which a system of care is established, and barriers encountered and solutions implemented; (7) further identify, operationalize, and design a methodology for tracking factors that are reflective of the plan or that may affect outcomes/implementation; (8) identify potential sources of qualitative data useful for fully describing the system of care/ implementation or that may relate to outcome evaluation, and determine processes for obtaining this information; and (9) develop a data collection time schedule for all aspects of the evaluation.

Years 2-6: Once the plan has been developed, the Evaluation Team will monitor and track the extent to which the plan is implemented over time and collect the information on the various process and outcome variables that have been identified as important for fully understanding the system of care and its development.

Outcome evaluation data will focus on changes in : (1) the community system of care ; (2) organizations; (3) service providers; and (4) children and families. Both quantitative and qualitative methods will be used to collect data over time. A longitudinal design will be used to assess changes at all system levels. Changes in service use (types, units of services, service duration), and associated costs and service outcomes (child and family clinical and functional status) will be assessed not only over time for children served in the SOC but also in comparison with a cohort of children who entered the MHMRA and/or DePelchin Children's Center systems in 2000 and who would have met the criteria for SOC services.. Children and families who enter the SOC will be tracked for three years or until service completion, whichever comes last. A diffusion model (Rogers, 1983) will guide the evaluation of the spread of the wraparound model throughout the service community; a social network structure model (McCarty, 2002) and related analysis and graphing software will be used to assess the changes in interagency linkages that contribute to the extension and sustainability of the SOC beyond SAMHSA funding; Kirkpatrick's (1994) Evaluation of Training Effectiveness model will be used to assess the changes in individual service providers knowledge, and application of the wraparound model as well as evidence-based/promising practices.

Process monitoring and evaluation efforts will track the inputs and outputs of program implementation, i.e. "map and measure" the processes, in order to (1) assess the fidelity of implementation to what was proposed; (2) fully describe key processes that occur; (3) assess progress towards goals and objectives in accordance with the proposed timeline and provide feedback so that needed changes can be made in a timely manner; and (4) capture contextual information in a manner that will be useful for explaining what contributes to outcome successes and failures. These processes will facilitate the replication of the model in other Texas communities. Both quantitative and qualitative data will be gathered to document project activities and processes. One fulltime Process Monitor will be hired to assist in capturing all process data and assist in documenting program fidelity to SOC principles and values.

B. Data derived from the National Evaluation will be used to increase effectiveness of various components of our system of care. During monthly meetings with the Alliance, current analysis and status of data collection will be presented. These meetings will be one forum in which evaluation data will be used to identify areas for further change strategies and to make decisions regarding program changes. Potential decision areas will include need for increasing service quality, additional efforts needed for the diffusion of SOC/Wraparound principles, and need for further training.

We plan to develop and initiate a Continuous Quality Improvement plan within Year 1 in order to effectively utilize local and national evaluation findings. Analysis of data will provide a feedback loop which will allow staff and partners to continuously improve service delivery areas. Outcome data on child clinical and family functional status will be used to assess change over time. Data gathered from consumer satisfaction and children's progress toward their goals will reflect quality of service delivery. The Board will periodically review local evaluation data and recommendations made by the National Evaluation contractors to develop local SOC policies.

The Board and Administrative Team will develop informational presentations with data from the evaluation. It is anticipated that presentations to local, state and national community funders including Texas legislators will generate funding sources for our children and youth with SED and their families. We anticipate that our local data will also be used to support the development of new legislation to initiate and sustain systems of care statewide.

C. Knowledge and experience of individuals with evaluation expertise who are available from local universities or the community: See Section G for staff expertise. Several of the proposed team members have previous experience in National Evaluation participation and the DePelchin Children's Center (DCC) Research and Grants Management (RGM) Department is currently involved with two such efforts - a ***SAMHSA-funded Child Traumatic Stress initiative and an ACF-funded replication of a child abuse and neglect prevention program.*** In both cases, all of the required information needed for the National Evaluation is being collected and submitted to national databases per the funder's request.

D. Facilities, equipment, materials and resources dedicated to evaluation activities: Quantitative and qualitative information will be collected from all system levels: the Alliance, organizations, individual service providers, and youth and caregiver/family members using a variety of National Evaluation identified instruments. Schools will be contacted for information on attendance and academic achievement. In separate focus groups, caregivers and youth will also provide other feedback, concerns and recommendations for change. Costs associated with service usage will be obtained. Aggregate information will be shared with the Alliance and incorporated into the ongoing local evaluation.

A variety of methods, including surveys, record review, clinical instruments, structured interviews, and focus groups will be used depending on the type of data being collected. The Caregiver and Youth instruments already identified have been included in the proposed evaluation design and any changes requested by the national evaluation will be incorporated. The Evaluation Team will collaborate with the Alliance to assure that all appropriate descriptive information is obtained for children served. The data for the National Evaluation, as well as other data specific to the proposed objectives, will also be maintained locally by the Evaluation Team. Via surveys and structured interviews, Alliance and other organizational executives and service providers will give information regarding diffusion of wraparound principles, infrastructure, policy and procedure changes and information regarding linkages with other organizations in the network. Persons who attend trainings will report on the usefulness of the training and how/to what extent they have implemented what they learned. During the planning year and thereafter, as needed, a variety of standardized instruments will be purchased/used to collect information. These instruments include those listed for the National Evaluation, the Wraparound Fidelity Index, the System of Care Practice Review, a social network questionnaire (to be selected), and other surveys, as determined to be needed.

Repeated data collection and analysis will occur at designated points in time in order to assess changes over time. It is expected that, given the scope of the data proposed to be collected, subsequent data collection activities will be staggered. Initial and repeated assessments of individual children and families will depend on when a child enters the SOC. Children and families will be followed for three years, with the clinical outcome assessment and service utilization/experience data updated every 6 months. A timeline for all specific data collection and analysis will be developed during the first year in collaboration with the national evaluation initiative. Following procedures already established at DCC, clinical data will be scored and results returned to the care management team to be used in case planning.

Data collection methodology and statistical analysis will be driven by the needs of the National Evaluation and local programs. Both quantitative and qualitative methods will be used. SPSS will be used to examine changes and relationships among quantitative variables. N-Vivo will be used to analyze qualitative data. Special Social Network Mapping tools will be used to analyze and graph participation and interactions

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C. Knowledge and experience of individuals with evaluation expertise who are available from local universities or the community: See Section G for staff expertise. Several of the proposed team members have previous experience in National Evaluation participation and the DePelchin Children's Center (DCC) Research and Grants Management (RGM) Department is currently involved with two such efforts - a **SAMHSA-funded Child Traumatic Stress initiative and an ACF-funded replication of a child abuse and neglect prevention program.** In both cases, all of the required information needed for the National Evaluation is being collected and submitted to national databases per the funder's request.

D. Facilities, equipment, materials and resources dedicated to evaluation activities: **Data:** Quantitative and qualitative information will be collected from all system levels: the Alliance, organizations, individual service providers, and youth and caregiver/family members using a variety of National Evaluation identified instruments. Schools will be contacted for information on attendance and academic achievement. In separate focus groups, caregivers and youth will also provide other feedback, concerns and recommendations for change. Costs associated with service usage will be obtained. Aggregate information will be shared with the Alliance and incorporated into the ongoing local evaluation.

A variety of methods, including surveys, record review, clinical instruments, structured interviews, and focus groups will be used depending on the type of data being collected. The Caregiver and Youth instruments already identified have been included in the proposed evaluation design and any changes requested by the national evaluation will be incorporated. The Evaluation Team will collaborate with the Alliance to assure that all appropriate descriptive information is obtained for children served. The data for the National Evaluation, as well as other data specific to the proposed objectives, will also be maintained locally by the Evaluation Team. Via surveys and structured interviews, Alliance and other organizational executives and service providers will give information regarding diffusion of wraparound principles, infrastructure, policy and procedure changes and information regarding linkages with other organizations in the network. Persons who attend trainings will report on the usefulness of the training and how/to what extent they have implemented what they learned. During the planning year and thereafter, as needed, a variety of standardized instruments will be purchased/used to collect information. These instruments include those listed for the National Evaluation, the Wraparound Fidelity Index, the System of Care Practice Review, a social network questionnaire (to be selected), and other surveys, as determined to be needed.

Repeated data collection and analysis will occur at designated points in time in order to assess changes over time. It is expected that, given the scope of the data proposed to be collected, subsequent data collection activities will be staggered. Initial and repeated assessments of individual children and families will depend on when a child enters the SOC. Children and families will be followed for three years, with the clinical outcome assessment and service utilization/experience data updated every 6 months. A timeline for all specific data collection and analysis will be developed during the first year in collaboration with the national evaluation initiative. Following procedures already established at DCC, clinical data will be scored and results returned to the care management team to be used in case planning.

Data collection methodology and statistical analysis will be driven by the needs of the National Evaluation and local programs. Both quantitative and qualitative methods will be used. SPSS will be used to examine changes and relationships among quantitative variables. N-Vivo will be used to analyze qualitative data. Special Social Network Mapping tools will be used to analyze and graph participation and interactions

among those involved in the system of care. Cost analysis will include cost benefit (e.g. decrease use/costs of inpatient facilities and law enforcement contacts), cost effectiveness (e.g. reduce costs associated with improvement in specific outcomes) and cost utility (e.g. reduce costs associated with overall improvement in child and family outcomes). Descriptive, repeated measures, correlational and other multivariate techniques will be used, depending on the questions to be answered and the level of data to assess changes at all system levels. Relationships between process and outcome data will be examined. Relationships between other aspects of the SOC will also be determined. Feedback from data analysis will guide stakeholders in identifying areas for further attention.

E. Data entry, storage, management, analysis and reporting: Evaluation staff and parent partners will receive training in all aspects of data handling from correct entry procedures to confidentiality. Youth and family information will be kept secure and confidential as data will be stored by client number and the master list that links client names to numbers will be kept in a separate location from the database. Forms, tests and other documents will be kept in locked file cabinets in locked offices, and an IRB approved protocol for access to information will be strictly followed. When possible, the Evaluation Team will use **computer-assisted technology or Teleform-formatted instruments and scannable software**, to collect and enter data into databases. Data from focus groups will be transcribed and hand entered. A Research Technician will assist with Teleform and hand-entered data. Data will be stored in SPSS, Access, and Excel databases maintained within the Research and Grants Management department at DePelchin Children's Center (DCC). Software to assess network characteristics of the system of care will be purchased. Personal computers used for data entry purposes are networked through a server and password protected. The local network system requires user identification and password access. Backup copies of the network data system will be made daily and data will be stored on diskettes with a backup copy residing with evaluators and another with Alliance administrative personnel. The Evaluation Team will comply with all funder-required reporting schedules. The team will meet weekly to plan and implement evaluation strategies, and monthly process monitoring reports will be presented to the Alliance. Results from baseline data regarding system capacity and structure as well as information from record analysis of the comparison cohort, will be presented as it is analyzed. Results from other outcome analysis will be presented on an ongoing annual basis so that trends may be ascertained.

F. Current Management Information System: Numerous systems gather administrative and service utilization data in Harris County. These include the HCPS EVOLV system, The HCJPD JIMS system, and the MHMRA System. The DePelchin Children's Center MIS will be used to store and retrieve data regarding the local SOC during the 6 year cooperative agreement. However, these are not linked to provide cross-system utilization, and the feasibility of creating one integrated MIS is not high due to individual agency confidentiality concerns and HIPPA regulations.

G. Youth and Family Involvement in Evaluation Activities: Youth and Parent members of the Evaluation Team will be full partners in designing and implementing the evaluation. They will assist in choosing final instruments, translate materials as needed, assist with data collection, analysis and interpretation of results, and collaborate with other team members to co-present at conferences, write papers for publication, and to develop and disseminate written materials for diverse audiences. Their involvement will be particularly relevant in determining feasibility of the protocol and ensuring its cultural and linguistic competency. Other members of the ET will provide necessary training and assistance to help these youth and parents actively participate in the evaluation efforts. This will include such things as interviewer training, focus group facilitation, survey design principles, and data scoring. They will also help other members of the Team to understand findings and to identify contextual factors that may influence the findings. A pool of at least four parents and youth will be involved as members of the Evaluation Team.

One paid part-time parent partner will assist in coordinating and conducting family focus groups and analyzing data.

H. Local Evaluation Activities: In addition to collaborating with the National Evaluation to study child and family outcomes longitudinally, local evaluation efforts will focus on assessment of the system of care and its transformation based on several theories of change. These include Kirkpatrick's (1994) evaluation of training effectiveness model, Rogers's Diffusion of Innovations, and McCarty's Social Network structure model (2002). In particular, data will be collected on factors among the system service providers that contribute to the increase in knowledge of SOC principles, acceptance and adoption of Wraparound and other evidence based practices, and development of interrelationships and network linkages resulting in integrated service provision for children with SED and their families.

We will also document and measure the provision of culturally and linguistically appropriate services and supports to non-English speaking families due to the need to serve recently immigrated Hispanic, Asian and African families. Furthermore, findings on local systems change will be provided to local and state policy makers and funders to help reallocate funds and resources (sustainability), create and fund more culturally and linguistically competent services and supports, and transform the delivery of mental health services to local children/youth with SED and their families.

I. Institutional Review Board: DePelchin Children's Center Institutional Review Board (IRB) will be used for review of protection of human subjects. This IRB is currently being used for a current SAMHSA – funded Child Traumatic Stress initiative and an AFC-funded replication of a child abuse and neglect prevention program. See Protection of Human Subjects – Section H.

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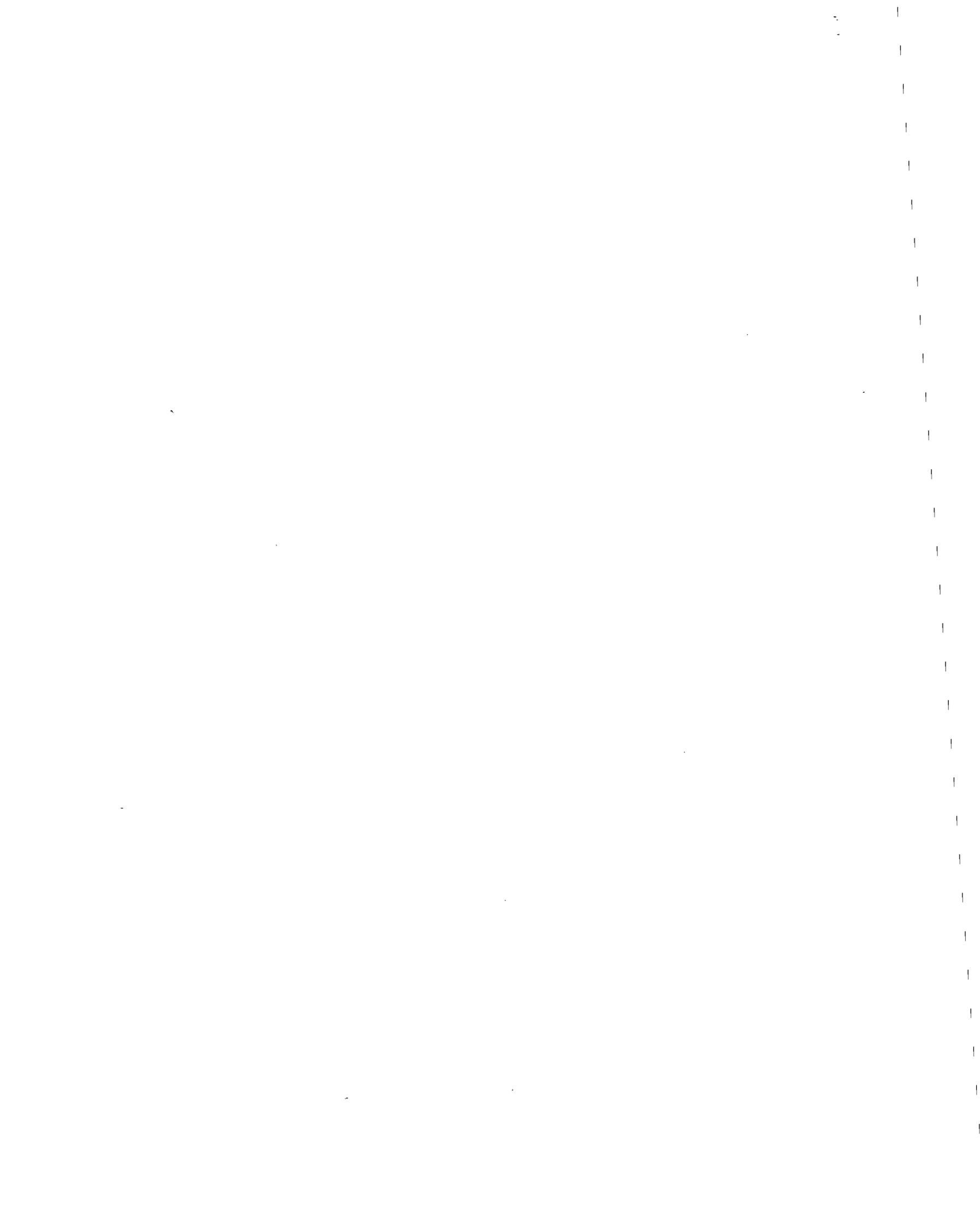
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Section F - Budget Justification, Existing Resources, Other Support

BUDGET JUSTIFICATION: (2005)

Personnel:

Job Title	Name	Annual Salary	FTE	No. of Months	Federal Share	Non-Fed Share/ Funding Source
Administrative Team						
Principal Investigator			.05	12	-0-	\$6020.00 HCPS
Project Director		57,000	1.00	12	\$57,833	-0-
Training Coordinator		43,000	1.00	10	35,833	-0-
Family Coordinator		37,000	1.00	10	30,833	-0-
Social Marketing Coordinator		43,000	.50	10	17,917	-0-
Admin. Assistant		25,000	1.00	10	20,000	-0-
Receptionist		20,000	1.00	6	10,000	-0-
Total:					\$172,416	\$6,020
Alliance Resource Coord. Team						
Clinical Services Director II		\$100,000	.10	12	-0-	\$10,000 HCJPD
Care Coordinator Supervisor		43,000	1.00	10	\$35,833	-0-
Care Coordinator (7)		35,000	1.00	2	40,833	-0-
Parent Partner (5)		32,000	1.00	2	26,667	
Parent Partner (2)		33,000	1.00	12	-0-	66,000 MHMRA
ARCT Coordinator		37,000	1.00	12	-0-	37,000 HCPS
Total:					\$103,333	\$113,000
TOTALS:					\$275,749	\$119,020

Staff currently employed will begin working on the Alliance project in Year 1 Month 1. However, if staff must be hired, it usually takes approximately two months for jobs to be posted, persons interviewed and staff hired. In the last two months of Year 1, seven (7) care coordinators will be hired by HCPS and embedded in four agencies: HCPS, HCJPD, MHMRA, and DCC. Two fulltime Parent Partners are already employed by MHMRA; two Parent Partners will be hired by HCPS in the final two months of year 1. In years two and thereafter we will hire a total of 7 care coordinators, 7 parent partners and one supervisor coordinator in the ART division.

Subtotal on 424A, Section B, 6a: \$394,769

Fringe Benefits:

Employer	Rate	Federal Share	Non-Fed Share	Total cost
HCPS/HCJPD	35.34%	\$97,450	\$18,737	\$116,187
MHMRA	25%	-0-	16,500	16,500
TOTAL		\$97,450	\$35,237	\$132,687

fringe Benefits (HCPS)	Percentage
FICA	7.43%
Group Health Insurance	15.56%
Worker's Comp	1.86%
Unemployment	0.16%
Retirement	10.05%
Supplemental Death Benefit	0.28%
TOTAL	35.34%

The MHMRA rate of 25% is similar to the above rate, minus the 10.05% retirement paid to Harris County employees. Based on the projected salaries for employees of the TRIAD agencies, it is expected that in Year 1 the fringe benefits will total \$131,949.00.

Subtotal on 424A, Section B, 6b: \$132,687

Travel:

Local Mileage:

\$85 x 6 care coordinators/parent partners x 2 months	\$1,020
\$85 x 4 Admin. Team Staff x 10 mo.	3,400
	\$4,420

Conference:

\$1200 x 10 people x 2 trips	\$25,000
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In Year 1, multiple meetings will require local travel for the Program Director, Training Coordinator, Parent Coordinator, Social Marketing Coordinator and Care Coordinator supervisor. Care coordinators and parent partners will be hired in the last two months and are expected to incur travel expenses equal to administrative staff. Currently, mileage is charged at a rate of \$.405/mile. Total: \$6,460 for local mileage and parking. In accordance with SAMHSA mandates, we anticipate sending 10 persons to SAMHSA sponsored meetings two times in Year 1 for 3 days/trip. (airfare @ \$800 x 10 x 2 = \$16,000; per diem = 10 persons x 3 days x 2 trips x \$150 = \$9,000). Total = \$25,000. All travel will be paid by federal funds.

Subtotal on 424A, Section B, 6c: \$29,420

Equipment:

Phone system for 10 ISDN lines (installation and monthly charges)	\$ 4,600
Conference Room furnishings (12 chairs, table, credenza)	4,000
Workstation furnishings @ \$3,000/unit x 10	30,000
Desktop Computers @ \$1,500 x 10	15,000
Laptop Computers @ 2,500 x 3	7,500
Desktop Printers @300 x3	900
Cell Phones @30 x 6 x 10 mo.	1,800
Cell Phones @30 x 5 x 2 mo.	300

The above equipment is needed to conduct business by the Administrative Team. All equipment will be paid for by federal funds.

Subtotal on 424A, Section B, 6d: \$64,100

Supplies

Office supplies / Postage @ 75 x 10 months x 10 staff	\$ 7,500
Meeting supplies @ \$100 x 12 months	1,200

Printing and Publications

10,000

In Year 1, it is anticipated that training of staff, Alliance partners, providers, and family members will encumber significant printing and publications costs. Meeting supplies will include notebooks, pens, paper, and food supplies for Governing Board and Administrative Team meetings. All costs will be paid by Federal funds.

Subtotal on 424A, Section B, 6e: \$18,700

Contractual:

Contractor	Product	Federal Share	Non-Fed Share	Total Cost
Baylor College of Medicine (for Administrative Team component)	Contract for John Sargent, M.D. to perform .4FTE as Clinical Director	\$85,000		\$85,000
DePelchin Children's Center (for Evaluation component)	Community-based Utilization-focus Evaluation Year 1	200,000	-0-	200,000
ChildBuilders (for State-Local Liaison component)	Liaison between state and nat'l legislators to lobby for sustainability of local SOC	25,000	17,000	42,000
Training & Technical Assistance (see Training budget breakdown below)	Consultant rate = \$1,000/day = \$1000 travel, per diem, hotel, car rentals; = food for meetings.	110,000	-0-	\$110,000
Multi-systemic Therapy training	Clinical training, program license & travel expenses;	35,000	-0-	35,000
Youth & Family interviewers (for Evaluation component)	200 hours x \$12/hr to gather data from families re: SOC services	2,400	-0-	2,400
Youth Coordinators (2) (for Admin. Team)	\$30,400 / 2 = \$15,200 each staff	30,400	-0-	30,400
TOTAL		\$487,800	\$17,000	\$504,800

Subtotal on 424A, Section B, 6e: \$504,800

Baylor College of Medicine has agreed to contract out the services of John Sargent, M.D., at a .4FTE for \$85,000 to provide administrative, training and clinical psychiatric services to the Harris County Alliance for Year 1. Dr. Sargent is a local psychiatrist with extensive background in child psychiatry, systems of care, and training of medical professionals in various aspects of systems of care provision.

DePelchin Children's Center will provide evaluation leadership for Year 1 for \$200,000. Parents and youth will be hired on a contract basis (100 hours x \$12/hr) to collect various data from consumers, providers and community stakeholders throughout Year 1.

ChildBuilders will contract with the Alliance to provide the state-local liaison function of this cooperative agreement. They have a proven history of representing the needs of Harris County children to local, state and

federal policymakers and legislators. They will provide part-time staff and office space. Federal share will be \$25,000.

Two part-time Youth Coordinators will be hired on a contract basis to develop activities to represent the voice of youth with SED and represent their needs to the Alliance. Each will work an average of 20/hr week to share a contract job at \$31,200.at \$12.00/hr for 10 months in Year 1.

Other:

Other Costs	Federal Share	Non-Fed Share	Total Cost
Office space 1500 sq.ft @ \$12.66/sq.ft	\$18,990	-0-	\$18,990
Parent Stipends @ \$35/each x 200	7,000	-0-	7,000
Youth/family focus group meetings \$250/mtg x 3	750	-0-	750
TOTAL	\$26,740	-0-	\$26,740

Subtotal on 424A, Section B, 6h: \$26,740

HCPS will incur the cost of office space for 10 Alliance administration team staff. It is estimated that the space needed by these employees will be 1,500 feet and will be located in an HCPS building with a square foot rate of \$12.66/sqft.

In order to assist families and youth in participating in all Alliance functions (Governing Board, other meetings, trainings) we plan to pay each family member a stipend of \$35/day to cover transportation and attendance cost. We plan on approximately 200 units of family participation, totaling \$7,000 in Year 1.

MHMR will conduct two (2) focus groups in Year 1 to obtain data from youth and families. It is estimated that food and materials will total \$250/meeting, totaling \$500 in year 1.

Total Direct Charges:

Federal Share: \$999,959

Matching: 171,260 + 406,583 (40.66% of federal share only) = \$577,843

The sum of 6.a-6.h on Form 424A equals: **\$1,171,216**

Indirect Costs:

The total indirect costs are provided as non-federal matching funds by Harris County Protective Services at a rate of 40.66% as designated by Harris County Office of Budget Management. Indirect costs are charged only on proposed Federal share funds and total: **\$406,583**

TOTALS:

Grand total for direct and indirect costs = **\$1,577,799**

Training Budget Proposal

Year 1

Training

Administrative Leadership Training

Governance Board Training

	Frequency	Total Cost
Logic Model (2 days)	1	
National Consultant @ \$1000/day		2,000
Plus per diem, car rental, hotel & travel		<u>1,000</u>
		3,000
Basic Systems of Care (1 days retreat)	1	
Consultant 2 @ \$1000/day		2,000
Plus per diem, car rental, hotel & travel		<u>2,400</u>
		4,400
Policy Issues (1 day per quarter)	4	
Consultant 1 @ \$1000/day		4,000
Plus per diem, car rental, hotel & travel		<u>1,200</u>
		5,200
Partnering with Parents (1 day)	2	
Consultant @ \$1000/day		2,000
Plus per diem, car rental, hotel & travel		<u>2,400</u>
		4,400
	Subtotal	17,000

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Rationale: The first year of the grant, the infrastructure will be developed. This will involve building the leadership team and addressing agency policies. They will need training on the basic philosophy of System of Care. They would also need introduction into the Wraparound Process and how that is implemented. As agency policy issues arise, they would need to be addressed, as well as identifying legislative issues that need to be addressed, such as Medicaid waivers.

Agency Staff Training

Basic Systems of Care (2 days)	4	
Consultant 1 @ \$1000/day		8,000
Plus per diem, car rental, hotel & travel		<u>4,800</u>
		12,600
Train the Trainers (6 days)	1	
Consultant 1 @ \$1000/day		6,000
Plus per diem, car rental, hotel & travel		<u>1,100</u>
		7,100
Supervisor Training (4 days)	2	
Consultants 1 @ \$1000/day		8,000
Plus per diem, car rental, hotel & travel		<u>2,400</u>
		10,400
Strength-Based Assessments	4	
Consultant @ \$1000/day		4,000
Plus per diem, car rental, hotel & travel		<u>4,800</u>
		8,800
Wraparound Facilitation (4 days)	1	
Consultant @ \$1000/day		4,000
Plus per diem, car rental, hotel & travel		<u>1,200</u>
		5,200
	Subtotal:	\$44,100

53

Rationale: All agency staff, parents and community programs involved with the program will need training in Basic Systems of Care. In the first year, this would be about 200 people. Additionally, all training departments within the agencies (10 people) will need to be involved in being trained, so that after the first year they can begin implementing the training routinely to new agency staff. Once the trainers are trained, to insure fidelity to the process, the consultant will be paired with an agency trainer to conduct the trainings during the first two years of the grant. In addition, supervisors will be trained in how to help build skills for their staff. The end of the first year, a group of designated agency staff and parents will be trained in wraparound facilitation, to begin implementation. During the second year, more facilitators would be trained and training would then include advanced issues in wraparound. The first year it is also important to train staff and

parent on strength based and functional assessments. This will help with the necessary shift in approach to a strength-based model. Parents will be involved in all trainings with the staff, both as trainers and as participants.

Parent Involvement Training

Parents as Partners	2 days	2	
Consultant @ \$1000/day			4,000
Plus per diem, car rental, hotel & travel.			<u>2,400</u>
			6,400
Leadership	1 day per month	12	
Consultant @ \$1000/day			12,000
Plus per diem, car rental, hotel & travel.			<u>9,000</u>
			21,000
		Subtotal:	\$27,400

54

Rationale: In addition to receiving the same basic training as staff members, parents need additional training on how to partner with agencies. This would include training on agency mandates and functions, as well as processing through issues specific to parents. Parents involved at the Governance level, at the Administrative level and on the Alliance Team would also need training on leadership. This will help the parents to continue to organize into an effective advocacy group.

Clinical Staff Training

Multi-systemic Therapy		1	
MST Trainers			24,000
Program License			5,000
Travel Expenses			<u>6,000</u>
		Subtotal:	35,000

Rationale: There are currently no known trained MST therapists in the Harris County area. The plan is to train 20-25 people in order to have a pool of therapists to provide this best-practice therapy for youth and families throughout the area.

Rationale: The CAFAS instrument will be one of the evaluation tools used to work with the families referred to the project. In order to effectively use this tool, two people will be sent to become trainers and then train evaluators as needed.

Cultural Competence Training (2 day)	6	
Multicultural Alliance, Asian Community Center, and AAMA		6,000
		Subtotal:
		13,200

Rationale: Cultural competence is a vital component of implementing SOC. This training would need to be done for all agency staff, parents and the community. This is the foundation for acceptance and relationships necessary for community adoption of the SOC model and how we approach the clients.

5
5

Food, supplies for miscellaneous training planning meetings:		\$2,300
	Total	\$145,00

EXISTING RESOURCES:

The combined efforts of three public child serving county agencies (Harris County Protective Services [HCPS], Harris County Juvenile Probation Department [HCJPD], and Mental Health and Mental Retardation Authority of Harris County [MHMRA]) enable the Alliance for Children and Families to have a vast array of resources available for expansion and sustainability. TRIAD agencies all have major office facilities and satellite offices throughout Harris County which will allow for community-based services to youth with SED and their families. The three agencies also have extensive training capacity both in staff and logistical supports. HCPS Training Institute has a videoconferencing network which links the Training Institute to 6 local CPS offices, juvenile and family court judges, Texas Children's Hospital, and the University of Texas-Harris County Psychiatric Center (UT-HCPC) TeleHealth network.

MHMRA of Harris County provides a full range of services including: community support services for First Time Offenders, supported employment services, psychopharmacology services, the NeuroPsychiatric Center (an inpatient and 23-hour observation mental health public facility), individual and group psychotherapy services, family support services, and Crisis Intervention Services provided in collaboration with the Houston Police Department. MHMRA accepts Medicaid and CHIP funding. In addition, UT-HCPC provides in-patient psychiatric services to Harris County children and youth. In collaboration with HCJPD, a specialized unit for juvenile offenders provides services to up to 17 youth.

The HCPS Accounting Department manages over \$18 million of county, state and federal funds and is equipped to provide fiscal management for the SAMHSA project. All TRIAD agencies have internal MIS and data management capacity, as well as experience in working on federal, state and local grant projects.

DePelchin Children's Center Research and Grants Management has over staff who perform evaluations for and manage federal and state grants, as well as numerous foundation grants.

Local family support groups are involved in Alliance activities and are a great contribution to our existing SOC. Local family members have been active in the Harris County Community Resource Coordination Group and the Harris County Integrated Funding Initiative, which merged into the Harris County Alliance for Children and Families in 2003. Several parents serve on local child service boards such as the Alliance multi-agency group, ROCK Advisory Board, MHMRA Advisory Boards, and provide community services such as facilitating Juvenile Probation parent support groups for families with juveniles who have mental health issues, and attending school ARDS meetings to advocate for youth and families in a school setting. Local NAMI and Federation of Family support is evidenced by attached letters of support.

Baylor College of Medicine is a leading medical school teaching facility with world-renown expertise in many areas, including Child Psychiatry. John Sargent, M.D., is nationally and internationally known for his work in the area of child psychiatry, systems of care development, and training of medical providers in the area of systems of care and primary health.

The Texas Medical Center in Houston is home to a large array of medical schools, nursing schools, allied health training programs. These training programs are attended by an international array of current and future interdisciplinary medical service providers who will benefit from training in the area of systems of care, and it is anticipated that knowledge gained from Alliance training will allow future international development of SOCs. Texas Children's Hospital is located in TMC and teams with University of Texas

Medical School and Baylor College of Medicine to provide a full range of medical, psychiatric and psychological services to all Harris County youth, including Medicaid and CHIP recipients

The Harris County Hospital District provides primary health services in numerous community-based clinics and public hospitals including Ben Taub Hospital and Lyndon Baines Johnson Hospital. The Baylor College of Medicine Child Psychiatry Clinic is located in Ben Taub and directed by John Sargent, M.D. Under the directorship of Stuart Yablonsky, M.D., Dr. Sargent provides a full range of in and out-patient child psychiatry services to Harris County indigent and underinsured youth with SED. All services are covered by Medicaid and CHIP for income-eligible youth.

Numerous local non-profit service agencies provide Substance abuse services. The largest is the Council on Alcohol and Drugs Houston, which provides a wide range of services to youth, including prevention programs in schools, assessment services, community information, group, individual and family counseling services, as well as information and referral services. The Council will assist in developing a strategic plan of service for substance abuse needs of children and youth receiving Alliance services.

Houston Works is a non-profit organization that provides vocational services to local youth, and has worked closely with HCJPD in providing services to juveniles with mental health issues. Services include assessment, vocational training and placement / coaching.

OTHER SUPPORT:

HCPS, in collaboration with Texas Department of Family and Protective Services –Region 6, provides child protective services to Harris County youth. The state's involvement in the development and expansion of the Alliance has been strong since 2000, when the agency was actively involved in securing state TDPRS funds from the Texas Integrated Funding Initiative. State TIFI funding has been an important element in sustaining the Alliance since 2000.

Local collaboratives have been supportive of the local SOC expansion and provided input and letters of support in obtaining SAMHSA funds for Alliance expansion. The Harris Community Access Collaborative comprised of over 100 Harris County public and private safety net health systems, coalitions, advocacy groups and service providers has pledge support for Alliance expansion, and its provider network can be utilized to provide services and supports to youth and families with SED. Gateway to Care, the service arm of the HCAC, is a Community Access Program funded by the Health Resource and Service Administration. Gateway to Care works with local communities in developing Federally Qualified Health Centers, which will be entry points for children and families into the Alliance SOC.

The Mental Health Association of Greater Houston has been supportive of the development and sustainability of systems of care for local youth with SED and their families. They initially applied for and received state funds to develop our local system of care. The MHA currently administers a private foundation grant from the Jet Foundation to develop SOC services for juvenile offenders. MHA will collaborate with the Alliance to avoid duplication of services and expand services and supports to local youth and families.

Section G: Biographical Sketches and Job Descriptions

Position: Principal Investigator (.1FTE): George Ford, J.D., will devote 10% (.1FTE) of his time to the Harris County Alliance project.

Job Description:

General Description:

Serves as the official responsible for the fiscal and administrative oversight of the Alliance cooperative agreement. Responsible and accountable to the Harris County Alliance for the proper conduct of the cooperative agreement. Is legally responsible and accountable to funder for the performance and financial aspects of activities supported through the cooperative agreement. Responsible for liaison with State officials and agencies. Devotes 4 hours per week to these duties.

Qualifications:

Advanced degree in social science or law. Past experience in providing executive directorship to a large non-profit or governmental child and family service agency. Knowledgeable in program development and sustainability of large programs and projects. Proficient in community collaboration with local, state and national leaders and legislators regarding children's issues. Ability to communicate effectively, both orally and in writing.

Duties and Responsibilities:

1. provide leadership for fiscal and administrative oversight of the Harris County Alliance for children and families
2. provide leadership for Governing Board functions and development of memoranda of agreements for Alliance community partners
3. liaison with state and local officials and agencies re: local system of care issues

Position: TRIAD Program Director(.1FTE):

Duties: Ms. Deborah Colby is the HCPS TRIAD Prevention Program Director and will assume the overall supervision of the System of Care development and implementation. Ms. Colby will work in conjunction with the Alliance Governance Board in the development of the strategic plan. She will provide oversight to the implementation of the system of care network and service delivery components.

Qualifications: Ms. Colby has an MSW degree and is a Licensed Clinical Social Worker (LCSW) and Marriage and Family Therapist (LMFT). She has over 25 years experience in working with children and families in the mental health, child protection and juvenile justice systems. Her experience includes case management, family therapy and supervisory/administrative roles. She has been involved in numerous collaborative projects and service delivery systems.

Position: Project Manager (1 FTE) (to be hired)

Duties: The Project Manager will dedicate 100% of his/her time to the Alliance project. This estimate is based on the level of complexity of the tasks involved in creating a countywide system of care. This position will assist in hiring and will be responsible for supervising the Alliance Administrative Team staff. This position will facilitate and ensure development and application of a strategic plan, implement goals and objectives, and administer the mandates of the comprehensive strategic plan for implementing the proposed system of care. He/she will serve as a liaison between the governing board and the administrative team and hire key staff. In addition, the Project Manager will monitor compliance with the cooperative agreement, evaluate vendor contracts, and review youth treatment and support needs.

Qualifications: To be hired. The prospective candidate will have substantial experience in program development, community collaboration, administration and knowledge of child welfare, juvenile justice, and mental health services to children, youth and families. The candidate will have at least a Masters Degree in social services, and experience in multi-agency collaboration, administration and supervision. Familiarity with systems of care development and sustainability is a plus..

EVALUATION TEAM (4.0FTE)

Duties: An Evaluation Team (ET) comprised of youth and parents representative of the culture/language subpopulations in the targeted service area and research personnel from the Research and Grants Management Department of DePelchin Children's Center (DCC), will design and conduct the process and outcome evaluation components. In addition to youth and parent representatives, the ET will include a 50% Evaluation Team Coordinator (decreasing to 30% in Years 3-6), 2 Full-time Outcome Evaluators, a Full-time Process Evaluator/Monitor, and a full-time (only 50% Year 1) Research Technician. The Evaluation Coordinator will direct implementation of the National Evaluation sponsored by the CCMHS Program and establish performance measures. The Evaluation Coordinator will assist in developing the Alliance strategic plan to ensure client confidentiality. One FTE doctoral level Outcome evaluator embedded within the Alliance Team will coordinate the day-to-day evaluation efforts, train and supervise parent partners and Alliance staff involved in evaluation tasks, and collaborate with national evaluators; one FTE doctoral level Process evaluator will provide macro-system evaluation direction and products; a one FTE Masters level Research Associate will provide data input and analysis and a .5FTE Parent Partner will assist in obtaining and analyzing family data. As appropriate, members of the Team will collaboratively present at local, regional and national conferences, publish in peer-reviewed journals, and develop and disseminate other written materials for diverse audiences in the community.

Evaluation Coordinator: Jeannette Truxillo, DrPH, is employed by DePelchin Children's Center Research and Grants Management Department. She will coordinate the activities of the Alliance Evaluation Team and evaluation personnel assigned to the project, directly supervise the two outcome evaluators and the research technician and be responsible for securing IRB approval (from DCC's IRB) to conduct the project evaluation. She will also coordinate the project with the national evaluation efforts.

Two Outcome Evaluators (one identified; one to-be-hired; 100% time each) will design, collect and analyze data to address the outcome objectives of the SOC. Tasks for both Outcome Evaluators include: collaborating with the evaluation team to discuss validity of instruments and choosing final instruments; securing/getting translated evaluation instruments as necessary; formatting data collection instruments into computer-assisted technology (e.g. Media Lab) or into Teleform to streamline data collection; developing and maintaining databases, statistical data analysis and reporting.

- The **Lead Evaluator** will have a Ph.D. in a social or behavioral science, at least 3 years experience in program evaluation and demonstrated expertise in advanced statistical data analysis, evaluation design, database development, qualitative and quantitative data analysis, report writing and professional presentation. This person will co-locate with the Administrative Offices of the Alliance.
- The second **Evaluator** (Ms. Anna Abarquez, M.A.) has a Master's degree in Developmental Psychology. During the last five years, she has evaluated numerous projects at DePelchin Children's Center, including a state-funded multi-site evaluation and ACF and SAMHSA-funded projects. She has demonstrated expertise in all of the areas listed above. Ms. Adrienne Legendre has a master's degree in Social Work and several years of experience in program monitoring/process evaluation, including fidelity assessment. She has demonstrated skills in, database creation and maintenance, fidelity design, intermediate-level data analysis, report writing and professional presentation.

The Process Evaluator/ Monitor (100% time) will collaborate with the Project Director and the Alliance to identify those components of the logic/theory of change underlying the system of care model relevant for fidelity monitoring. The PM will coordinate with the ET to operationalize the System of Care fidelity indicators and track/monitor the fidelity aspects of the actual implementation. The PM also will identify and

document contextual factors that may influence the system of care, examine relationships among various process variables and will collaborate with other members of the ET to incorporate process information into the outcome evaluation. Finally, the PM will track the progress of process objectives, report monthly on this progress as well as results from the fidelity monitoring, work with the Project Director and the Alliance to brainstorm solutions to barriers towards achieving objectives/fidelity and subsequently monitor the implementation and success of those solutions. This person will report to the Process Monitor Supervisor in DCC's Research and Grants Management Department.

Youth and Parent members of the Evaluation Team will be full partners in designing and implementing the evaluation. They will assist in choosing final instruments, translate materials as needed, assist with data collection, analysis and interpretation of results, and collaborate with other team members to co-present at conferences, write papers for publication, and to develop and disseminate written materials for diverse audiences. Their involvement will be particularly relevant in determining feasibility of the protocol and ensuring its cultural and linguistic competency. Other members of the ET will provide necessary training and assistance to help these youth and parents actively participate in the evaluation efforts. This will include such things as interviewer training, focus group facilitation, survey design principles, and data scoring. They will also help other members of the Team to understand findings and to identify contextual factors that may influence the findings.

Position: Clinical Directors (.50 FTE):

Duties: John Sargent, M.D., will devote 10 hours per week (.4FTE) and Diana Quintana, Ph.D. will devote 4 hours (.1FTE) per week as part-time Clinical Directors of the Alliance service provider network. They will participate in the development of the strategic plan, identify evidence-based and promising practice treatment methods, services and supports, and work with national and local evaluators to develop performance standards. They will develop guidelines for specific clinical interventions and the delivery of systems-of-care services, will identify interdisciplinary training curricula and will implement training initiatives for caregivers, mental and medical health professionals, partners and future practitioners.

Qualifications: Dr. John Sargent is a Professor of Psychiatry at Baylor College of Medicine and Director of Child and Adolescent Psychiatry at Ben Taub Hospital in Houston, Texas. He is board certified in General Psychiatry, Child and Adolescent Psychiatry and Pediatrics. Dr. Sargent has co-authored and co-edited books, lectured on a variety of topics both nationally and internationally and written more than 70 articles. He was honored by the Academy of Child and Adolescent Psychiatry as an Outstanding Mentor. Previous positions include Director of Residency Training and Education at the Hospital of the University of Pennsylvania, Director of Child Psychiatric Training at the Philadelphia Child Guidance Clinic, and Associate Professor of Psychiatry and Pediatrics at the University of Pennsylvania School of Medicine. He will dedicate 40% of his time to the project.

Diana Quintana, Ph.D., is the Deputy Director of Mental Health and Mental Retardation Services for Harris County Juvenile Probation Department, and has more than 14 years of clinical experience. She supervises the coordination of all HCJPD clinical services. She also assists with identifying youth offenders with SED who are in need of acute or sub-acute hospitalization at the University of Texas-Harris County Psychiatric Hospital. Prior experience includes Chief Psychologist for the Child and Adolescent Forensics Unit for the MHMRA of Harris County and psychologist for the Houston Independent School District. She will dedicate 10% of her time to the project.

Position: Alliance Resource Coordination Team Coordinator (1 FTE)

Ms. Lauren Laughlin Moore will serve as the fulltime (40 hour per week) ARCT Coordinator. Her duties will include organization of all Alliance Intake activities (screening and coordinating case staffings, implementing and developing system of care mandates and serving as a liaison to local child-serving agencies to provide seamless comprehensive services to youth). Ms. Moore has been the Harris County Community Resource Coordination Group Coordinator for over 6 years, and has more than 15 years experience in the medical and mental health service coordination field. Previous employment experience includes positions as Admissions Supervisor, Admissions Coordinator and Intake Counselor.

Position: Family Coordinator (1 FTE)

(to be hired)The Family Coordinator will dedicate 40 hours per week to provide practitioner, staff and parent training and provide general consultation services to the Alliance. The Family Coordinator will work closely with other county and state parent organizations to develop and/or expand their capacity to serve local families according to their cultural and linguistic needs. He/she will serve as an Alliance Administrative Team member, will monitor parents serving as Alliance parent coordinators, assist and participate in training initiatives and community outreach efforts. This position will be hired in Year 1. The ideal candidate will be the caregiver of a child with serious emotional disturbance and have thorough knowledge of the systems of care including the provision of services, community-based social services, identifying advocacy needs and identifying the strengths and weaknesses of the systems of care. See job description.

Position: Youth Coordinators (two .5 FTE positions)

(to be hired)

Two half-time Youth Coordinators will each devote 20 hours per week to create a formal youth support organization for Harris County, provide advocacy, staff training

and general consultation for the Alliance. They will provide and promote positive engagement of youth in the Alliance system of care, and will help establish activities geared to prevention and youth development among high risk populations of children and youth. Additionally, the Youth Coordinators will establish relationships and work closely with youth organizations in the county and state and serve as a member on the Administrative Team. The youth coordinators will be able to determine advocacy needs and to develop, implement and evaluate service effectiveness. They must be knowledgeable of service delivery systems for youth with mental health needs. The youth coordinators shall work effectively within the community, with Alliance personnel, participating agencies, youth, parents and other organizations.

Position: Training & Technical Assistance Coordinator (1 FTE) (to be hired)

General Description:

Will work 40 hours per week and serve as the central point within the Alliance for Children and Families for strategizing and assessing the technical assistance needs of the local system of care community and as the link with Technical Assistance Partnership for accessing the appropriate technical assistance needed by the Alliance.

Qualifications:

Advanced degree in social sciences or education. Past experience in providing training and coordination of training endeavors in a medium to large non-profit or governmental child and family service agency. Knowledgeable in educational processes, adult learning, program development, curriculum development and past experience and knowledge of systems of care for children/youth with severe emotional disturbances and their families. Experience in group dynamics and excellent communication skills.

Duties and Responsibilities:

1. provide leadership in planning and developing a Training and Technical Assistance plan in collaboration with SAMHSA staff
2. coordinate training activities for diverse audiences (medical personnel, families, Masters level social service students, agency personnel in child service agencies, service providers, etc.)

Position: Care Coordinators (FTE 7.0), Parent Partners (FTE 3.0) & Supervisor (1FTE)

(to be hired) Beginning in Year 1, we will hire and train seven fulltime Care Coordinators, three Parent Partners and one fulltime Care Coordinator Supervisor. They will organize mental health and ancillary social services for youth and family using the wraparound model. Two care coordinators will be assigned to each of the TRIAD agencies: HCPS (child welfare), HCJPD (juvenile justice), and MHMRA (Mental health services, who has 3 Parent Partners on staff), and one to DePelchin Children's Center. All will be supervised by an Alliance Care Coordinator supervisor. Care Coordinators and parent partners will serve as a liaison between the family, the Alliance system of care, partnering host agencies and the child's wraparound team. They will work closely with Clinical Directors and the Training and Technical Assistance Coordinator to ensure appropriate care strategies are provided for youth and families.

Each Care Coordinator will have at least a Bachelors degree and 2 years experience working with a child-serving agency; or a Master's degree in some social science. Preferred experience includes working with specialized caseloads (mental health, disabled, at-risk/delinquent, abused and neglected, etc.), knowledge of the wraparound concept, community outreach, and the ability to speak languages required by the collaborative based on community assessments.

Parent partners must have at least a High School education and experience in working with multi-agency staff. These staff must have experience in providing care to a child/youth with SED.

Position: Administrative Assistant (FTE 2.0)

(to be hired) Two administrative assistants will provide full-time (40 hours per week) clerical assistance to the Governing Board, Project Manager, Technical Assistance Coordinator, Youth Coordinators, and Family Coordinator. Clerical assistance will include typing, data entry, copying, faxing, filing, scheduling meetings, and other duties as designated. Prospective employees must have 2 years experience working in a fast-paced and high-volume professional work environment. Other required experience includes knowledge of Excel, Access, Power Point, and Word.

GEORGE FORD

**Harris County Protective Services for Children and Adults
2525 Murworth
Houston, TX 77054
(713) 394-4064**

EMPLOYMENT

1979 to Present

Serves as Executive Director of Harris County Protective Services for Children and Adults (HCPS), a county department. The program is overseen by a 15-member board appointed by Commissioners Court. The program employs 234 staff and has a budget of over \$14 million.

Harris County Protective Services for Children and Adults provides direct services to youth through the 77 staff placed in 18 school districts as well as seven justice of the Peace Courts. Additionally, 24-hour services are provided at Chimney Rock Center, which also houses a 24-bed emergency shelter.

The county provides support services to the state program through the Children's Crisis Care Center, which provides a comprehensive evaluation to an average of 120 children per month entering care because of physical abuse or neglect. Additional funding supports the Regional Training Institute, as well as a medical and dental clinic.

In March of 2003, the Harris County Guardianship Program became a part of the HCPS. This program provides a full-range of services to adult Harris County residents who have been adjudged indigent and incapacitated by one of the county's probate courts and are now wards of the county.

1998 - 1999

January, 1998 - January 2000 - Served as Chair of the Youth & Family Services Division with responsibility for coordinating activity of six departments serving children and families. The departments in 1997 served 74,185 children and youth. The combined budget for the six departments, with a total of 1,382 staff, was \$64 million in fiscal year 1999.

1976 - 1979

Agency Attorney, Harris County Children's Protective Services. Responsible for administration of agency legal unit, including supervision of assistant agency attorney, three court liaison workers, and two secretaries. Responsible for coordination and presentation of all suits filed involving child protective cases in Harris County.

1972 - 1976

Legal Unit Supervisor, Harris County Children's Protective Services. Responsible for supervision of agency legal unit consisting of three court liaison staff and two secretaries. Coordination of all suits involving all protective cases filed in Harris County.

1970 - 1972

Protective Services Worker, Harris County Children's Protective Services. Provision of in-home services to an average caseload of thirty families.

EDUCATION

1970 Bachelor of Arts Degree; Sociology Major; East Texas Baptist College; Marshall, Texas

1976 Doctor of Jurisprudence Degree; South Texas College of Law; Houston, Texas

PROFESSIONAL AFFILIATIONS

State Bar of Texas

Licensed Master Social Worker, Advanced Practitioner

Council on Accreditation of Services for Families and Children, Inc.

Advisory Board Member, Child Advocates, Inc.

Council of Agency Executives - Advisory Committee to Child Welfare League of America's Executive Director

Biography

John Sargent, M.D.

John Sargent, M.D. is a Professor of Psychiatry and Pediatrics at the Baylor College of Medicine in Houston, Texas. He is also Director of Child and Adolescent Psychiatry at the Ben Taub Hospital in Houston, a community hospital serving almost entirely underinsured and impoverished families from a wide range of cultures within the city. Through July 2001, Dr. Sargent was the Director of Education and Research, and Dean of the Karl Menninger School of Psychiatry and Mental Health Sciences. As Director, Dr. Sargent coordinated and supervised strategic planning for all aspects of research and education.

Dr. Sargent received his BS from MIT and his M.D. at the University of Rochester School of Medicine. He completed residency training in Pediatrics at the University of Wisconsin, and residency training in General Psychiatry and Child and Adolescent Psychiatry at the University of Pennsylvania.

Dr. Sargent is a Child and Adolescent Psychiatrist, Pediatrician and Family Therapist who has focused his career on ensuring attention to the needs and healing capacities of the family for children with pediatric illness or significant behavioral or emotional difficulties. He has consistently worked within academic medical centers and throughout has taught medical students, and Pediatric, Psychiatric and Child and Adolescent Psychiatry residents.

Dr. Sargent was previously the Director of Residency Training and Education at the Hospital of the University of Pennsylvania, and Director of Child Psychiatry Training at the Philadelphia Child Guidance Clinic. He was also Associate Professor of Psychiatry and Pediatrics at the University of Pennsylvania School of Medicine. Dr. Sargent is nationally known in Child and Adolescent Psychiatry and Family Therapy. He is an Approved Clinical Supervisor of the American Association of Marriage and Family Therapy, a member of the Editorial Boards of the Journal of the American Academy of Child and Adolescent Psychiatry and Family Process. He has been honored as Outstanding Mentor by the Academy of Child and Adolescent Psychiatry. He is co-author of the book Madness, Chaos and Violence: Therapy with Families at the Brink, and co-author of Primary Care Pediatrics. Dr. Sargent has written over 70 articles on a number of topics including family therapy, eating disorders, adolescent suicide, and training in mental health care. He is highly regarded as a lecturer, having spoken on a wide range of topics both nationally and internationally.

Dr. Sargent is the Deputy Director of the Eastern European Child Abuse Project of the Children's Mental Health Alliance and the Soros Foundation. He also has been a member of the Kosovo Professional Education Collaborative sponsored by the American Family Therapy Academy and the University of Pristina, Kosovo for the past 18 months.

These efforts have focused upon building mental health programs and trauma recovery programs internationally, especially in the Balkans, Eastern Europe and the former Soviet Union. He is interested in promoting family recovery and healing in association with violence, trauma, abuse and such phenomena as eating disorders, suicidality and PTSD. He has also been working with three colleagues to define the family analogue of attachment which promotes family belonging, family support for affective experience and the development of a coherent family narrative underlying personal self-definition and personal coherence.

SYNOPSIS VITAE

Dr. Quintana has been working as the Administrator of Mental Health Services for the Harris County Juvenile Probation Department since May, 2001. In this capacity, she oversees the continuum of services for children with mental health needs, who are also involved in the juvenile justice system. Dr. Quintana coordinates the clinical services provided at all the juvenile justice county institutions including the West Dallas Juvenile Detention facility. She also assists with the identification of seriously disturbed juvenile offenders who are in need of acute or sub-acute hospitalization at the Harris County Psychiatric Hospital.

Prior to working for the Harris County Juvenile Probation Department, Dr. Quintana was the Chief Psychologist for the Child and Adolescent Forensic Unit for the Mental Health and Mental Retardation Authority of Harris County. In this capacity, she performed psychological evaluations of juvenile offenders including competency and lack of responsibility assessments, made recommendations regarding treatment and placement needs, and provided supervision to other psychologists in the unit. Starting September 1, 2002, Dr. Quintana will again assume supervision of the Forensic Unit.

Dr. Quintana obtained her Ph.D. in Clinical Psychology from Oklahoma State University in 1987, and has been a resident of Houston since completing her internship and the Houston Veterans Administration Hospital the same year. Dr. Quintana has also worked as a Psychologist for the Houston Independent School District doing counseling and crisis intervention with Houston area children.

EDUCATION:

- 1981 Ph.D. Sociology (specialized in Demography and Medical Sociology) University of Georgia, Athens, GA (4.0 GPA)
1976 M.A. Sociology (specialized in Demography) University of Georgia, Athens, GA (4.0 GPA)
1969 B.A. Sociology (minor in Psychology) Furman University, Greenville, SC (Cum Laude)

PROFESSIONAL EXPERIENCE:

- July 1989 – present: Director, Research and Grants Management, DePelchin Children's Center, Houston, Texas.
Developed and currently manage the Research and Grants Management department, with a staff of 23 people. Am responsible for continued development of research, evaluation and grant management capabilities of the department. Assure that grants and contracts are implemented according to grantor guidelines and in keeping with project's goals and objectives. Assist members of the senior management team and program managers with program development, planning and evaluation and obtaining needs assessment information. Assist program managers to design state-of-the-art programs within their service area.
- Nov. 1986 – June 1989: Research Associate, DePelchin Children's Center, Houston, Texas.
Designed and conducted basic research and program evaluations. Assisted in development and coordination of a case-management information system within and among various programs in the social work division of the agency. Also was Project Coordinator for a Children's Trust Fund grant to assess a short term sexuality curriculum for residential teenagers. Activities included: Evaluation and research design; needs assessment; project supervision; statistical data analysis; grant writing; curriculum development; data base creation and management; report writing; computer usage
- Sept. 1988 – May 1994: Adjunct Professor, University of Houston, Department of Sociology.
Courses taught include Program Evaluation, Research Methods, Applied Sociology, Sociology of Family, and Introductory Sociology.
- Dec. 1986 – Sept. 1993: Faculty Associate, University of Texas Health Center, School of Public Health, Houston, Texas
Designed and conducted a project to identify and evaluate primary prevention programs of elder abuse and battered woman. Also wrote and obtained a grant from the Hogg Foundation to study stress and coping behavior of young teens at risk for suicide.
- Oct. 1984 – July 1986: Research Specialist, Texas Department of Mental Health/ Mental Retardation, Houston, Texas.
Designed and conducted applied research in comparative services and prevention. Research covered such topics as adolescent cluster suicide (Project Director); public awareness of genetic counseling services, quality of life of mental health patients and evaluation of case management of mental health patients. Special duties included: Applied research design; Consultation; Statistical data analysis; Computer usage - IBM; Cyber; Grant writing; Grant

supervision; Hiring and supervision of interviewers; Data collection and data management; Report writing/publication; Presentation at professional meetings

OTHER PROFESSIONAL EXPERIENCE: Principal Investigator- (1) Designed and conducted a project to identify and evaluate primary prevention programs in child abuse and neglect that have data to support their claim of primary prevention. Project culminated in a publication being sold nationwide. (2) Designed and conducted a national survey of adolescent suicide intervention/prevention services. The study was requested by the Secretary of Health and Human Services' Task Force on Youth Suicide. Four papers discussing the study were presented at a conference in Oakland, CA in June, 1986.

PUBLICATIONS AND REPORTS (Harding, formerly known as Simmons)

Harding, J. (1998). *CHERISH A Neighborhood Final Report to National Center for Child Abuse and Neglect*, Grant No. 90-CA-1556.

Harding, J. (1998) *CHERISH A Neighborhood Replication Manual* submitted to the National Center for Child Abuse and Neglect, Grant No. 90-CA-1556.

Harding, J. (1998). *Project CONNECT Final Report* submitted to the Children's Bureau/Department of Health and Human Services, Grant No. 90-CO-0720.

Harding, J. & Legler-Luft, L. (1993). Outcome evaluation of the PAL (Preparation for Adult Living) program. pp. 144-146. In Edmund V. Mech and Joan R. Rycraft (Eds.) *Preparing Foster Youths for Adult Living*. Child Welfare League of America: Washington, D. C.

Dworkin, R., Harding, J. and Schreiber, N. *Parenting or Placing: Decision Making by Pregnant Teens*. *Youth and Society*, 1993, 25(1): 75-92.

Weinman, M. and Simmons, J. *Building Internal Resources in Maladaptive Pregnant Teens*. *Residential Treatment for Children and Youth*, 9(1): 17-27.

Weinman, M., Robinson, N., Simmons, J., Schreiber, N. and Stafford, B. *Pregnant Teens: Differential Pregnancy, Resolution, and Treatment*. *Child Welfare*, 1989, 68(1): 45-55.

Davidson, L., Rosenberg, M., Mercy, J., Franklin, J., and Simmons, J.. *An Epidemiologic Study of Risk Factors in Two Teen Suicide Clusters*. *Journal of the American Medical Association*, November, 1989.

Simmons, J., Comstock, B., and Franklin, J. *Prevention/Intervention Programs for Suicidal Adolescents*. *Prevention and Intervention in Youth Suicide*, 1988, Vol. 3, Wash. D. C.: US Government Printing Office

HONORS AND AWARDS: 1981 Outstanding Young Women of America Award; Phi Kappa Phi; 1978 B. O. Williams Award (outstanding graduate student in sociology)

Jeannette Belcher Truxillo, Dr.P.H.
Research Associate Supervisor

Education:

12/2003: Dr.P.H., Community Health - Health Promotion/Health Education, University of Texas, School of Public Health, Health Science Center at Houston, Houston, TX

Dissertation: Cross-cultural Assessment and Persistence of Attention Deficit Hyperactivity Disorder Symptoms in Middle School Students

5/1991: M.P.H., International and Family Health, University of Texas, School of Public Health, Health Science Center at Houston, Houston, TX

Thesis: A Satisfaction Survey of Low Income Women Using Prenatal Care at a Community Health Center

8/1973: B.S. in Medical Technology, Marquette University, Milwaukee, WI

Professional Experiences:

2/2002- Present: Research Associate Supervisor, Research and Grants Management, DePelchin Children's Center, Houston, TX

4/2000- 2/2002: Grant Evaluation Supervisor, Research and Grants Management, DePelchin Children's Center, Houston, TX.

9/1998- 4/2000: Research Assistant II, Program Evaluation, Research and Grants Management, DePelchin Children's Center, Houston, TX.

10/1995-1/1998: Project Coordinator, NIH/Women's Health Initiative grant: Ethnic Variations in Women's Attitudes Toward Hysterectomy, Southwest Center for Prevention Research and Center for Health Promotion Research and Development, University of Texas, School of Public Health, Health Science Center at Houston, Houston, TX.

12/1994-10/1995: Graduate Assistant for Behavioral Sciences, Center for Health Promotion Research and Development, University of Texas, School of Public Health, Health Science Center at Houston, Houston, TX

2/1994-12/1994: Research Assistant, Centers for Disease Control and Prevention grant: Development of New Interventions for Smoking Cessation: Maintenance and Environmental Tobacco Smoke Protection in Low Income Pregnant Women and Their Partners, Center for Health Promotion Research and Development, University of Texas, School of Public Health, Health Science Center at Houston, Houston, TX

10/1991-11/1993: Program Specialist, Project G.R.O.W/Early Childhood Intervention, Richmond State School, Texas Department of Mental Health and Mental Retardation, Richmond, TX

6/1988-12/1988: Program Coordinator and Graduate Assistant, South/North Center for Health Studies, International and Family Health Module, University of Texas, School of Public Health, Health Science Center at Houston, Houston, TX

1/1987-12/1987: Microbiologist, Infectious Disease Department, University of Texas, Medical School, Health Science Center at Houston, Houston, TX

9/1986-12/1987: Microbiologist, Fort Bend Community Hospital, Missouri City, TX

6/1978-6/1979: Director of School of Medical Technology, St. Luke's Episcopal Hospital, Houston, TX.

9/1973-6/1978: Microbiologist/ Teaching Coordinator, St. Luke's Episcopal Hospital, Houston, TX

Honors and Awards:

- 1995: Lamb Scholarship for Most Promising Student in Health Promotion/Health Education, School of Public Health, University of Texas -Houston
1993: Award - "Service to the Community by an Organization" Accepted on behalf of Project G.R.O.W from ARC (Association for Retarded Citizens) of Fort Bend County.

Review panels:

- 1/2005: Conference Abstract Thematic Review Committee, Society for Prevention Research
2/2002: Conference Abstract Review Committee, Society for Prevention Research
8/1991: External Review Panel Member, Texas Department of Health, HIV Health and Social Services Grant Applications, Greater Houston AIDS Alliance, Houston, Texas

Professional Organizations:

Society for Prevention Research

Presentations at Conferences: (formerly J. Goode)

- Truxillo, J.B., Roberts, R.E., Masse, L.C., & Mullen, P. D. (2004, February-March). Cross cultural assessment of the prevalence and persistence of Attention Deficit Hyperactivity Disorder in middle school students. Poster session presented at the 17th Annual Research Conference: A system of care for children's mental health: Expanding the research base, Tampa, FL.
Truxillo, J.B. & Verquer, M. (2002, November), Search for a Model TFTS family preservation program, Workshop presented at the 2nd Annual Partners in Prevention Conference, Texas Department of Protective and Regulatory Services, Austin, TX
Kaftarian, J., Bosworth, & Truxillo, J. (2000, December) Evaluating collaborations and program implementation. Panel presentation at the meeting of School and Community Action Grantees, SAMHSA, Washington, D.C.
Landis, J., Respass, D., Truxillo, J., & Florell, D. (2000, August) School-based mental health: Increasing community collaboration to reduce violence. Symposium presented at the meeting of the American Psychological Association, Washington, D.C.
Passaretti, A. & Goode, J. (1998, December) Therapeutic Mediation: Getting to the Heart of Permanency Planning, presented at the Child Welfare League of America Conference, Keeping the Promise of Permanency, San Antonio, TX.
Goode, J. (1992, November) Effective Parenting for Early Childhood, Presented at Children's Committee of Mental Health Association of Fort Bend County's Kids Count Conference III, Sugar Land, TX

Publications: (formerly J. Goode)

- Truxillo, J.B., Roberts, R.E., Masse, L.C., & Mullen, P. D. (in preparation) Psychometric properties of a self-report ADHD measure in a school based sample of Anglo and Mexican American students.
Truxillo, J.B., Roberts, R.E., Masse, L.C., & Mullen, P. D. (in preparation) ADHD in a community sample of cross cultural youth: Validation of a case definition and its use in determining self-reported prevalence and associated odds of medication use.
Truxillo, J.B., Roberts, R.E., Masse, L.C., & Mullen, P. D. (in preparation) Stability and persistence of ADHD dimensions and diagnostic subtypes.
Groff, J., Mullen, P., Byrd, T., Shelton, A., Lees, E. & Goode, J. (2000) Ethnic variations in women's attitudes toward hysterectomy: Results from focus group studies. *Journal of Women's Health*, 9(S2): S-39-S-50.

Adrienne L. LeGendre

1521 Harvard #D Houston, Texas 77008 Email adielegendre@hotmail.com Telephone: (832) 723-2597

PROFESSIONAL PROFILE

A masters level social work professional experienced in program evaluation and direct services to children and families. Expertise includes case management, volunteer recruitment, program monitoring, evaluation and public relations within the political arena

EDUCATION:

University of Houston, Houston, TX. May 2002.
Master of Social Work. Graduate School of Social Work
Certification in Mediation

Michigan State University, E. Lansing, MI. July 1999
Bachelor of Science in Psychology
Specialization in Health and Humanities

PROFESSIONAL EXPERIENCE

10/03 - Present *Evaluator II/ Process Monitor III.* DePelchin Children's Center, Houston, TX

- Monitor federally funded grant programs for compliance with established regulations. Develop and manage grant tracking tools and databases to monitor program activity.
- Prepare required reports, manuals, handbooks and procedures for grant funded programs.
- Facilitate monthly grant management meetings and conduct periodic staff trainings for successful project implementation.
- Write federal grant renewals for agency programs with multi-year funding.
- Coordinate subcontracts with collaborative agencies to provide services for grant funded programs.

5/02 - 9/03 *Grants Coordinator,* Casa de Esperanza, Houston, TX

- Prepared and monitored grant proposals and contracts for a 501(c)3 not for profit organization.
- Produced reports and grant presentations for board members and grantors.
- Researched new grant opportunities and prospective funding sources.

7/99 - 5/02 *Child Care Advocate, Children's Intake Crisis Shelter.* Casa de Esperanza, Houston, TX

- Responsible for the holistic care of children from birth to 6 years old. Provided health, educational, behavioral and psychological assistance for children at risk for abuse/ neglect or infected with HIV/AIDS.
- Developed a working knowledge of the different departments of the not for profit agency through a yearlong internship.
- Attended Permanency Planning meetings with CPS and legal hearings for child placement, assisted in home studies and foster parent trainings, community outreach, prepared for state licensing, prepared monthly residence and expense reports and provided Individualized Service Plans to caseworkers.

8/01 - 12/01 *Social Work Intern,* Progressive Voters in Action, Houston, TX.

- Assisted in coordinating two political campaigns for the 2001 Houston citywide election. Participated in canvassing events, telephone banking, data entry and political campaign strategy.
- Trained and recruited volunteers.
- Planned special events.

8/98-6/99 *Michigan State University Independent Study, CARE Program.*

- Coordinated efforts to evaluate a domestic violence program for effectiveness.
- Conducted pre and post interviews of subjects from the CARE program.
- Data collection and analysis using database software.

RECENT PRESENTATIONS:

"Just for Me Time: A parental self-nurturing component of Family Connections - Dickinson". Presentation at annual grantees meeting in Washington, D.C. May 2005

Lauren Laughlin Moore
417 Meadow Run Dr.
Friendswood, TX 77546

Summary: Over 13 years experience in the medical and mental health field that provides linkage to internal programs and external community and agency resources for youth with multiple and complex disabilities. Areas of strength include interpersonal communication skills, established interaction with youth-serving public and private agencies and providers and knowledge of public agency systems, services and community resources. Extensive knowledge of the systems of care philosophy and the wraparound process.

P R O F E S S I O N A L E X P E R I E N C E

Harris County Protective Services/

September 2001 to present

TRIAD Prevention Program
Houston, Texas

COORDINATOR OF HARRIS COUNTY ALLIANCE FOR CHILDREN AND FAMILIES
(FORMERLY CRCG)

Continuation of previous job responsibilities with the addition of receiving intensive training in systems of care philosophy and the wraparound process.

Coordinated trainings in systems of care and wraparound process for other agencies.

Assisted with coordination and implementation of the Harris County Integrated Funding Initiative, a funded pilot project through the State of Texas Integrated Funding Initiative.

Actively involved in the development of a systems of care for Harris County child-serving agencies.

Mental Health Association
Houston, Texas

October 1997 to 2001

COORDINATOR OF HARRIS COUNTY COMMUNITY RESOURCE COORDINATION
GROUP (CRCG)

Plan, coordinate and chair case staffing meetings of youth with multi-agency needs and complex disabilities.

Develop plans of service for youth, advocate for needed services and ensure service delivery.

Serve as liaison to local youth-serving agencies and provide linkage to resources for youth and their families.

Generate reports and maintain case records and documentation as required.

Network with public and private agencies and community providers to maintain working relationships and keep current with their services, program and resources.

Serve on numerous committees related to youth services.

Experienced in data entry, Microsoft Office and other office related equipment.

DePelchin Children's Center
Houston, Texas

January 1989 to July 1997

ADMISSIONS COORDINATOR AND INTAKE COUNSELOR

Liaison to youth-serving agencies, caseworkers and professional and medical staff and provided coordination of social services and mental health services for this agency.

Served as contact person for agencies, families and others requesting services and information about programs.

Facilitated entry and provided intake assessments for all programs, screened for appropriateness and staffed cases with program directors.

Maintained current referral and resource information about other agencies and providers in the community.

Ability to work in a busy environment prioritizing tasks, interacting with all levels of staff and exhibiting excellent people and communication skills.

Compiled monthly statistical reports and other documentation as requested.

St. John's Hospital
Nassau Bay, Texas

March 1988 to January 1989

ADMISSIONS SUPERVISOR

Supervised and conducted performance appraisals for admitting office staff of 10.

Hired and trained staff.

Scheduled and staffed admitting office personnel and emergency room admitting personnel.

Report writing as requested by Department Manager.

E D U C A T I O N

Stephen F. Austin University
Nacogdoches, Texas

1969 to 1973

BACHELOR OF BUSINESS ADMINISTRATION, MARKETING

Section H – Confidentiality and SAMHSA Participant Protection/Human Subjects

The Alliance for Children and Families will protect clients and staff from potential risks.

1. Protection of Clients and Staff from Potential Risks
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1. Identify and describe any foreseeable physical, medical, psychological, social, legal, or other risks or adverse effects as a result of the project itself or any data collection activity.

The collaborative process envisioned by the Alliance project poses no more than minimal additional risks beyond those that are already part of accepted standard care and mental health intervention with children with SED and their families offered by trained and accredited providers. There are multiple protections built into this integrated process. Protections have been built into the Alliance's treatment procedures, all of which will be in place for participants in this project. All clients will receive services from established child serving agencies and providers, and appropriate consent forms will be in place. Clients and their families will participate on a voluntary basis, and consent and release of information forms will clearly state any partner agencies and the ways in which the client information will be used and shared.

- **Physical:** No physical risks to participants have been identified or anticipated. Staff and/or parent partners could encounter physical injury from physically combative youth, and they will receive specialized training in working with physically aggressive clients to minimize injuries.
- **Medical:** No medical risks to participants have been identified or are anticipated. Children/youth receiving psychotropic medications as standard care will be closely monitored by medical clinicians.
- **Psychological:** No psychological risks to participants have been identified or anticipated. Only standardized and expert informed assessments will be used. If participants feel anxious or uncomfortable with the questions on any of the assessments, clinicians will be on hand to discuss these issues. Participants also have the option to refrain from completing assessments and still remain in the project. Staff and/or parent partners may encounter emotionally stressing situations, and will be provided with debriefing and counseling services as needed.
- **Social:** Stigma is frequently attached to mental illness and emotional disturbance. Such activities as entering a facility or publicly participating in the service systems could create misperceptions or result in social isolation or discomfort for parent and/or child. It is possible that nonprofessionals could become familiar with private treatment information and share with others outside the Family team. We will provide confidentiality training to all parent partners and informal supports to decrease the social stigma/breach of confidentiality. Community training will help to decrease social stigma.
- **Legal:** There may be inadvertent disclosure of information at the community level, however no more than minimal risk is anticipated as protocols that protect personal identifying information will be incorporated into all levels of data collection and referral processes. Inadvertent disclosure on the part of a professional, paraprofessional or administrative staff could have legal ramifications for the agency and the individual(s) involved. A mandatory Texas law is in effect regarding reporting of suspected child abuse and/or neglect. If staff see or suspect abuse or neglect, they are required to report it to the proper authorities. There is risk that the parent could undergo CPS investigation and intervention.
- **Other risks or adverse effects:** Specific therapeutic interventions could be publicly criticized and create unsubstantiated negative judgments within the community, or elevation of stigma.

2. Describe procedures to minimize or protect participants against potential risks, including risks to confidentiality.

Potential risks will be minimized in several ways. Risks will be minimized through provision of standard care services by accredited and certified agencies and practitioners, standardized and expert informed assessments, and full project disclosure through the informed consent process. Risk to confidentiality is minimized through anonymously coded data collection, protected data sharing, and referral protocols with signed releases of information and HIPAA protections.

3. Identify plans to provide guidance and assistance in the event there are adverse effects to participants.

If participants experience adverse effects, clinicians are available for counseling and revisions to service plans can be made. Participants will be given contact information to the Human Subjects Administrator for follow-up and modifications to the system network can be made through the Quality Improvement feedback process to be implemented.

4. Describe alternative treatments and procedures that may be beneficial to participants.

Family choice guides the actual implementation of the individual service plans. Families will have an array of services from which to choose such that the plan reflects the most effective, culturally competent, accessible and convenient services as possible. Periodic review of the individual service plan by the Care Management Team will ensure services are appropriate and acceptable to the child and family. If any service does not meet expectations for beneficial care, other services can be chosen.

2. Fair Selection of Participants

1. Describe the target population(s) for the project, including age, gender, and racial/ethnic background and note if the population includes homeless youth, foster children, children of substance abusers, pregnant women, or other targeted groups.

The target population for the project will include all children and youth in Harris County from birth to 21 years of age who are multi-agency users and meet DSM criteria and their families. Harris County has a total population of 3,596,082 (U.S. Census, 2003 with 1,042,856 children and adolescents who represent 33% Caucasian, 20% African-American, 42% Hispanic, and 5% Asian and other race/ethnicities (*Texas KIDS Count 2003*). The fastest growing segments are the Hispanic and Asian populations. Total Harris County population is 49.8% male and 50.2% female (2000 Census). As children will be referred from a wide range of providers (both members and non-members of the Alliance network), children will include special populations such as foster care, homeless, juvenile justice, and those at risk for out of home placement.

2. Explain reasons for including groups of pregnant women, children, people with mental disabilities, people in institutions, prisoners, and individuals who are likely to be particularly vulnerable to HIV/AIDS.

This client population of children is expected to have numerous behavior problems and co-occurring disorders. Therefore, it is quite likely that eligible clients could have mental disabilities, be supervised by the juvenile justice system, be pregnant, and be vulnerable to exposure to HIV/AIDS. These and other needs would be addressed in the individual service plan.

3. Explain the reasons for including or excluding participants.

The only reason for excluding participants will be if referred children/youth do not meet eligibility criteria. Participation in the SOC and its services is voluntary once eligibility is determined. Foster care children have the guardianship of CPS and additional client advocates will be appointed if needed. Homeless youth are determined to be emancipated but an advocate will be appointed if the team determines the need or the youth requests one.

4. Explain how you will recruit and select participants. Identify who will select participants.

Clients will enter the system of care project through referrals from agencies and providers who are both members and non-members of the Alliance. The Care Coordinator of the Alliance will screen referred clients for eligibility into the project. It is expected that participants will represent the range of race/ethnicities needing treatment in the Houston area and could include homeless and foster care children/youth. Once the yearly proposed client capacity is reached, subsequent children/youth will be provided community resources for follow-up care and continue case management through their referring agency until an opening develops in the current year or the next year begins.

3. Absence of Coercion

1. Explain if participation in the project is voluntary or required. Identify possible reasons why participation is required, for example, court orders requiring people to participate in a program.

Participation in the project services, data collection and national data sharing is considered voluntary for all clients and families. Client and family informed assent and consent will be integral in this process such that participants understand the parameters of the project before documenting their acceptance of services and involvement in data collection.

2. If you plan to compensate participants, state how participants will be awarded incentives (e.g., money, gifts, etc.).

Participants will be offered money in the form of gift cards or cash as compensation for their time while completing follow-up assessments and participating in focus groups. Parents and youth who are involved in the various Alliance Committees for planning and evaluation purposes will be offered stipends for their participation.

3. State how volunteer participants will be told that they may receive services intervention even if they do not participate in or complete the data collection component of the project.

The informed consent process will describe to clients and families that they can still receive services even though they may not complete the data collection component. Furthermore, the process and its concomitant documentation will also explain that if clients and their families do not complete assessments, their individual service plan may be incomplete and if participants refuse to complete follow-up assessments their treatment progress may not be updated.

1. Data Collection

1. Identify from whom you will collect data (participants, family members, teachers, others).

Describe the data collection procedures and specify the sources for obtaining data (e.g., school records, interviews, psychological assessments, questionnaires, observation, or other sources).

Where data are to be collected through observational techniques, questionnaires, interviews, or other direct means, describe the data collection setting.

Data will be collected from individual clients, their parents, school records, service providers, agency administrators and other relevant stakeholders using a variety of methods (e.g. structured interviews, self administered questionnaires, psychological assessments, observation, abstraction of clinical records). Data will be collected at various locations such as within agency/clinic offices, client/family homes, or community settings as appropriate and convenient to the client and family.

2. Identify what type of specimens (e.g., blood, urine) will be used, if any. State if the material will be used just for evaluation. Describe how the material will be monitored to ensure safety of participants.

Specimens such as blood or urine would be collected only in situations to monitor the safety of certain standard medication levels or for evaluation purposes to assure the effectiveness of substance abuse treatment. These specimens would be collected and handled only by the service providers that are designed and accredited for such purposes, thereby assuring ethical practices are followed.

5. Privacy and Confidentiality

1. Explain how you will ensure privacy and confidentiality. Include who will collect data and how it will be collected.

Privacy and confidentiality for participants will be ensured through several mechanisms. First, all agencies and providers will adhere to the rules of HIPAA, especially in the transfer of Protected Health Information (PHI). As this system of care is designed to promote the strengthening of referral linkages between providers in the care and support of clients, PHI will be respected and handled with the protections afforded by the law and with the permission of clients and their families. Second, all data will be coded such that client and family names are kept separate from the data in both the assessments and databases. Third, a Certificate of Confidentiality from the National Institute on Drug Abuse will be secured such that client records, especially those that contain information regarding use and treatment for alcohol and drugs is protected from court subpoena.

Data will be collected by the Coordinator of the Alliance for screening purposes, and clinicians, care managers, and members of the Evaluation team as appropriate to the type and timing. Data will be collected through self-report and interviews, observations, and abstraction of clinical records. All staff are required to uphold the confidentiality of client and family responses through their respective agencies and controls.

2. Describe:

How you will use data collection instruments.

Data will be used to determine client and family needs and strengths to develop and monitor the appropriateness of the service treatment plan as well as to determine change in outcomes for program effectiveness. Service usage, manner of implementation, and costs will be tracked for the purpose of ensuring fidelity to individual service plans and practice guidelines, associating outcomes with services, and providing information for the economic evaluation of the project.

Where data will be stored.

Hard copies of the data will be stored in locked file cabinets at the Research and Grants Management Department of DCC. Computer databases will be kept on password-protected computers of the Evaluation staff at DCC as well as the department's secure network drive.

Who will or will not have access to information.

Members of the Evaluation Team comprised of Evaluation staff from DCC and Parent and Youth participants will be the only persons having access to the raw data. Members of the Care Management Teams (i.e. clients, parents, clinicians) will receive scored data and clinical profiles with generated interpretation for determination and follow-up of their service plans for their designated clients and families. Referred agencies may have transferred information according to HIPAA protected protocols as appropriate to their service provision guidelines.

How the identity of participants will be kept private (examples: use of a coding system on data records, limited access to records, storing identifies separately from data).

All clients and their families will be given a special code that will be entered on all their questionnaires and assessment instruments to protect their identity. The master list of identifiers will be kept separate from the results of the assessments and the client/family codes will be the only linking variable entered into the outcome databases. Limiting access to these data records to only members of the Evaluation Team will also contribute to the confidentiality of client information.

3. The Harris County Alliance will agree to maintain the confidentiality of alcohol and drug abuse client records according to the provisions of Title 42 of the Code of Federal Regulations, part II by securing a Certificate of Confidentiality from the National Institute on Drug Abuse. This Certificate is a legally binding document whereby records of alcohol and drug abuse clients are protected from court subpoena.

6. Adequate Consent Procedures

1. List what information will be given to people who participate in the project. Include the type and purpose of their participation. Identify the data that will be collected, how the data will be used and how you will keep the data private.

Once referred clients are determined to be eligible for the project, they and their parents will be invited to participate in SOC project through an Informed Consent process. They will be given information on the (1) intent/purpose of the project, (2) why they are eligible, duration of the project, and description of the procedures to be followed, (3) description of any foreseeable or unforeseeable risks or discomforts of participation, (4) description of how these risks will be minimized, (5) description of the benefits expected from their participation, (6) disclosure of beneficial alternative courses of treatment, (7) the extent records will be kept confidential and who may have access to them, (8) description of any compensations for their time, (9) contact information for the project and Human Subjects Administrator, (10) statement of the voluntary nature of each component of the project, and (11) a statement regarding their decision to participate and that their signature indicates such. (see consent form in Appendix). Separate consent forms will cover participation in services, participation in the evaluation/data collection component, and permission for data sharing for the National Evaluation. Prospective participants will be told about the type of data to be collected (psychosocial and behavioral assessments and observation checklists, school records, and service provider checklists/interviews); the use of the data (to develop service plans,

determine change in outcomes, and monitor fidelity of service implementation); and procedures for keeping data confidential (coding and separation of identifiers).

- 2. Participation by clients is entirely voluntary. Families have the right to leave the project at any time without problems or retaliation. Possible risks from participation in the Alliance are stated above in Section 1: Protect Clients and Staff from Potential Risks.**

Client and family participation in services, data collection and data sharing components are all voluntary. Families have the right to leave the project at any time without problems. Possible risks from participation in the Alliance are stated above in Section 1: *Protect Clients and Staff from Potential Risks*. Plans for protection of clients from risks include use of professional and accredited service providers, use of standardized and expert informed assessments, and rules (i.e. HIPAA) and systems to maintain confidentiality of data such as coding and removal of identifiers.

- 3. Explain how you will get consent for youth, the elderly, people with limited reading skills, and people who do not use English as their first language.**

Informed consent to participate will be obtained from the family / legal guardian through signed documentation of consent forms. Informed assent by children/youth 10 years and older will also be obtained through signed documentation. Consent forms for adults will be written at about an 8th grade level or less and assent forms for children will be written at a lower grade level (i.e. 4th grade). Consent forms will also be translated into Spanish and possibly an Asian language if needed. For those clients and family members who have limited reading skills, points in the informed consent discussion will be referred to and read from the form so clients and their family members can follow along. Questions about the project and informed consent information will be asked of the prospective participants before asking them to sign to be sure they understand the elements of the project and consent process. They will also be given copies of the informed consent/assent documents for reference to project information as well as contact information for any questions that may arise about the evaluation and human subjects' issues.

- 4. Indicate if you will obtain informed consent from participants or assent from minors along with consent from their parents or legal guardians. Describe how the consent will be documented.**

Include sample consent forms that provide for (1) informed consent for participation in service intervention; (2) informed consent for participation in the data collection component of the project; and (3) informed consent for the exchange (releasing or requesting) of confidential information. Include forms in Appendix 4, "Sample Consent Forms).

- 5. Describe if separate consents will be obtained for different stages or parts of the project. (Will they be needed for both participation protection in treatment intervention and for the collection and use of data?)**

This project will involve the use of separate informed consent forms for participation in the treatment intervention, data collection/evaluation component, and data sharing with the National Evaluation.

- 6. If other consents (e.g., consents to release information to others or gather information from others) will be used in your project, provide a description of the consents. Will individuals who do not consent to having individually identifiable data collected for evaluation purposes be allowed to participate in the project?**

In addition to Informed consents and assents, participants and their families will also be asked about signing releases of "protected health information (PHI)" between network providers who would be

designated on their individual service plans. Signing permission to release this information follows HIPAA guidelines and would facilitate the transferal of important assessment and service plan results between providers allowing more effective use of services. Clients and families who do not give consent to participate in data collection or transferal of PHI will still be allowed to participate in project services, however, this may pose a barrier to formulation of a complete service plan as this data contributes to service plan development and tracking of progress.

7. Risk/Benefit Discussion

Discuss why the risks are reasonable, compared to the expected benefits and importance of the knowledge from the project.

All possible risks to clients and their families by participating in the project are considered no more than minimal and are reasonable compared to the expected benefits. Major improvements in child and family outcomes of participants over the 5 years of program delivery as well as strengthening of System of Care service integration and the increase in knowledge of the most effective service combination for client needs will lead to many potential benefits. These include participants' improved quality of life, system infrastructure and service integration expansion, and transformation of mental health service delivery at the program and policy level.

Protection of Human Subjects Regulations

Harris County Protective Services for Children and Adults, as the grantee, will comply with the Protection of Human Subjects Regulations (45 CFR 46).

Describe the process for obtaining Institutional Review Board (IRB) approval.

If awarded a SAMHSA cooperative agreement, the Alliance SOC – Evaluation Team will prepare and submit an application for approval from DePelchin Children's Center (DCC) registered IRB. The procedure involves the following steps:

with copies of the Informed consents and assent to the Human Subjects Administrator of DCC's IRB. The application includes the title of project, contact information, funder, project locations and duration, study description, participants and their protections, description of the informed consent process and compensations for participants, documentation of investigator Human Subjects Education, and list of attached documents (i.e. informed consents).

2. The Human Subjects Administrator forwards the application packet to the chair of the IRB or designee to review the exempt/accelerated review status of the project protocols. If the project and any of its components (integrated services, program evaluation, national data sharing) are determined to be non exempt from review, implementation of the project depends on meeting the criteria for IRB approval (according to regulations 45 CFR 46.111 and subparts B, C, and D). These include risks are no more than minimal, risks to subjects are reasonable in relation to benefits, equitable selection of subjects, subjects give informed consent and child (10 years and older) gives assent, informed consent is documented, data collection is monitored to ensure safety of subjects, and investigators protect the privacy of subjects. If risks to participants are considered to be more than minimal for any area, a full, convened IRB meeting will be needed for approval. Also if risk status is such, client advocates will be needed for foster care children and possibly for homeless, emancipated youth.

3. Once IRB approval is given for all components of the project, the Alliance SOC can begin screening and enrolling clients in the intervention.

The Alliance SOC will adhere to Protection of Human Subject Guidelines under the auspices of DCC's Federal Wide Assurance of Compliance, providing documentation that the Assurance of Compliance is on file with the Office for Human Research Protection (OHRP) at the time of client enrollment.

Appendix 1:
Letters of Commitment and Support
And
Memoranda of Understanding



TEXAS DEPARTMENT OF STATE HEALTH SERVICES

EDUARDO J. SANCHEZ, M.D., M.P.H.
COMMISSIONER

1100 W. 49th Street • Austin, Texas 78756
1-888-963-7111 • <http://www.dshs.state.tx.us>

May 9, 2005

Diane L. Sondheim
Deputy Chief
Child, Adolescent and Family Branch
Division of Service and System Improvement
1 Choke Cherry Road, Room 6-1043
Rockville, Maryland 20857

RE: Governor's Letter of Assurance for Harris County, Texas application for
SAMHSA Child Mental Health Initiative (SM-05-010) for FY 2005-06

Ms. Sondheim:

This is to verify that the Texas Department of State Health Services has been designated by the office of Texas Governor Rick Perry to be the agency with all assurance and signatory authority pertaining to the SAMHSA Cooperative Agreement for Comprehensive Community Mental Health Services for Children and their Families program.

It is understood that Harris County, Texas, is an applicant for SAMHSA Child Mental Health Initiative funds for fiscal year 2005-06, and will continue to seek funding through FY 2011 (a 6 year cooperative agreement). The lead agency and fiscal agent is Harris County Protective Services for Children and Adults (HCPS). The HCPS TRIAD Prevention Program will administer the *Harris County Alliance for Children and Families*. The Alliance is a multi-agency and family collaborative serving the function of the state-mandated Community Resource Coordination Group (CRCG) in order to coordinate and facilitate services and supports to children with special needs involved with multiple youth service agencies. The Alliance will provide local leadership in developing a system of care whose goal is to transform the delivery of mental health services to Texas children and youth with severe emotional disturbances (SED) and their families.

Services required in this cooperative agreement are covered in the State Medicaid Plan. The State of Texas have entered into participatory agreements under the State plan with Harris County Juvenile Probation Department, Mental Health Mental Retardation Authority of Harris County, and Harris County Protective Services to provide direct services required in the SAMHSA cooperative agreement. These agencies are qualified to receive payments under the State Medicaid Plan. All other designated and participating service providers will be required to enter into a participation agreement under the State Medicaid Plan and will be qualified to receive Texas Medicaid payments.

The vision and goals of *Harris County Alliance for Children and Families* system of care proposed under this Request for Applications are specifically included in the goals of the Texas Community Mental Health Services Block Grant Plan, as authorized in Section 564 (b) of the HCS Act, and in the Texas Mental Health Plan for Children and Adolescents with Serious Emotional Disturbances, submitted under Public Law (PL) 102-321. The Alliance system of care is consistent with plans proposed under all SAMHSA-funded State Incentive Grant and/or State Infrastructure grants awarded to Texas.

The Texas Department of State Health Services supports the development and expansion of the Harris County Alliance for Children and Families system of care, and is committed to assist in cultivating the community and interagency partnerships necessary to build and sustain this system of care.

Sincerely,

Dave Wanser Ph.D.

Dave Wanser, Ph.D.
Deputy Commissioner, Behavioral and Community Health Services
Department of State Health Services



April 25, 2005

Diane L. Sondheim
U.S. Department of Health and Human Services
Deputy Chief
Child, Adolescent and Family Branch
Division of Service and System Improvement
1 Choke Cherry Road, Room 6-1043
Rockville, Maryland 20857

Dear Ms. Sondheim:

I would like to express my full support of the Child Mental Health Initiative proposal (SM-05-010) submitted by Harris County to the Substance and Mental Health Services Administration (SAMSHA) for fiscal year 2005-2006. In 2003 Harris County Protective Services for Children and Adults and collaborating agencies and families initiated a system of care for children and youth with severe emotional disturbances and their families called the Harris County Alliance for Children and Families. Given the limited availability of children's mental health services in Harris County, the SAMSHA Cooperative Agreement would provide services to many children who would otherwise not be able to access services and help to transform the delivery of children's mental health services in Texas.

The proposed SAMSHA Cooperative Agreement with Harris County would provide for wraparound services to ensure that children with mental health issues in Harris County continue to receive the care they so desperately need.

By continuing to collaborate with community and state partners (parents, service providers, government entities), the Alliance will be able to provide a wider variety of services and integrate them into a comprehensive system of community-based mental health care for children and their families.

Sincerely,

A large, stylized handwritten signature in black ink, appearing to be "Robert Eckels".

Robert Eckels
County Judge

RAE/ls



CITY OF HOUSTON
Department of Health and Human Services

Bill White

Mayor

Stephen L. Williams, M.Ed., M.P.A.
Director
Health and Human Services
Department
8000 N. Stadium Drive
Houston, Texas 77054-1823

T.713.794.9311
F.713.798.0862
www.houstonhealth.org

May 6, 2005

George Ford, Executive Director
Harris County Protective Services for Children and Adults
2525 Murworth
Houston, Texas 77054

Dear Mr. Ford:

The Houston Department of Health and Human Services (HDHHS) is committed to improving the quality of life for Houston residents. For more than 100 years, the department has been providing health and social services to our community, including prenatal care, nutrition programs, restaurant inspections and environmental enforcement. HDHHS is always searching for strategies to enhance services to our residents, especially children. As a result, HDHHS is pleased to offer support to the Harris County Protective Services for Children and Adults (HCPS) and its partners to make effective mental health services systems change for our community's children who are identified as seriously emotionally disturbed (SED).

For the past several decades, through various partnerships, many agencies and organizations have coordinated mental health and other services to better effectuate services provided through the respective partners. Despite our best efforts, some youth continue to receive fragmented services with little or no long-term mental health treatment. Countless children are never assessed by mental health professionals and receive no mental health services at all. Financial constraints and lack of service coordination has exacerbated the problem for children with SED and their families. Lack of adequate community financial resources often prevents agencies from utilizing best practices, such as Multi-Systemic Therapy, and providing family-focused treatment plans. Resource pooling and integrating small existing community efforts is critical to systems of care improvement. HDHHS is enthusiastic about working with HCPS to streamline service coordination that will include eliminating barriers to information sharing, training initiatives designed to improve the knowledge of practitioners in the system of care, enhancing family-focused services and including youth and families in the Governing Board.

HDHHS is committed to participating in making changes in the Houston area to provide comprehensive mental health services to targeted youth with SED. As evidence of my agency's commitment to this endeavor, I have agreed to allow a member of my staff to serve on the Governing Board, assist in acquiring youth and parent participation in the collaborative and participate in training initiatives designed to improve our community's system of care. These services will include experienced staff, informed decision-making, time and effort, but no financial contribution. HDHHS believes these initiatives will assist this Houston to improve its system of care.

Mr. Ford, please accept this letter as verification of our commitment to our community's children and families. HDHHS looks forward to working with you on this effort to make valuable systems change for youth with SED.

Sincerely,


Stephen L. Williams, M.Ed., M.P.A.
Director

Council Members: Toni Lawrence Carol Mirns Galloway Mark Goldberg Ada Edwards Addie Wiseman M.J. Khan Pam Holm Adrian Garcia Carol Alvarado
Mark Ellis Gordon Quan Shelley Sekula-Gibbs, M.D. Ronald C. Green Michael Berry Controller: Annise D. Parker



NAMI Metropolitan Houston

19818 Summerset Way, Houston, TX 77094-3005

Phone: (281) 579-3750 Fax: (281) 579-3784

Cehamilton@aol.com

May 4, 2005

Harris County Protective Services for Children and Adults
Attention: Mr. George Ford, Executive Director
2525 Murworth
Houston, Texas 77054

Dear Mr. Ford:

On behalf of NAMI Metropolitan Houston, which includes 6 local NAMI affiliates in the Houston/Harris County area, I am pleased to support the Harris County Alliance for Children and Families: Mental Health Project (HCA) in the application to SAMHSA to improve mental health service opportunities for children and their families in Harris County, Texas.

Our specific interest in mental health care for children includes increasing education and training for those that have contact with children and families, which can be furthered through the NAMI Texas education course "Visions for Tomorrow."

The "Visions for Tomorrow" education course is not only for family members and caregivers but the curriculum also provides education/training for primary care health professionals and paraprofessionals who will benefit from coordination with our services.

Our nonprofit organization will support the project by providing "Visions for Tomorrow" education courses, taught by trained family members. Local NAMI affiliates also have support groups, monthly meetings with speakers and offer information and referral. NAMI also has an anti-stigma campaign on the national, state and local levels. For the past five years, NAMI Metropolitan Houston has been an active participant in Children's Mental Health Awareness Week, in collaboration with the Harris County Mental Health Mental Retardation Authority and other child serving agencies.

Please contact me at (281) 579-3750 or email CEHamilton@aol.com to discuss our services. Let me know if I can be of additional assistance.

Sincerely,

A handwritten signature in cursive script that reads "Carolyn E. Hamilton".

Carolyn E. Hamilton, President

HOUSTON METROPOLITAN FEDERATION OF FAMILIES FOR CHILDREN'S MENTAL HEALTH

May 12, 2005

Mr. George Ford, Executive Director
Harris County Protective Services for Children and Adults
2525 Murworth
Houston, Texas 77054

Dear Mr. Ford:

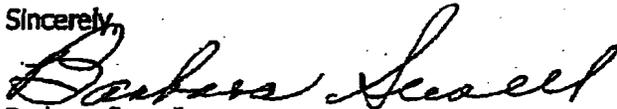
The Houston Metropolitan Chapter of the Federation of Families mission is to support and encourage families to advocate for the needs of their children who live with a variety of behavioral, emotional and mental disorders. For more than 15 years this organization has been working with parents, caregivers, legislators, public and private agencies and interested citizens to improve the systems of care for children with serious emotional disturbances (SED) and we are excited about the Harris County Protective Services for Children and Adults' collaborative application for funding available through the Substance Abuse and Mental Health Administration.

Families whose children have SED experience a multitude of needs that include therapy, education and other social services needs and caregivers are often in need of respite and other supports to assist them in caring for their loved one. Unfortunately, these services can be costly and lack of county-wide coordinated system of care only intensifies the problem. Other issues include lack of or adequate training for professionals who work with children with SED, legislative policies, and inappropriate services due to lack of family-focused services. Mr. Ford, your proposed collaborative strategy in streamline service coordination, advocate for children with SED at the legislative level, implement training initiatives designed to improve the knowledge of practitioners in the system of care, enhance family-focused services, and include your and families in the Governing Board will eliminate the barriers to effective care at its most important levels.

As evidence of our Chapter's commitment to improving the system of care in Harris County, we are prepared to provide a caregiver to participate on the Governing Board, provide information and training to all the systems of care participants, and assist the collaborative in acquiring youth and caregivers to participate at all levels of the systems of care.

If you have any questions or require any additional assistance from the Houston Metropolitan Federation of Families, please give me a call.

Sincerely,



Barbara Sewell
Executive Director

18203 Carriage Lane
Nassau Bay, TX.77058

PHONE (281) 335-5600
FAX (281) 773-4456
E-MAIL HoustonFFCMH@aol.com
WEB SITE <http://www.bffcmh.net>

Region



Superintendent

Scott Van Beck

14201 Briar Forest

Houston Texas, 77077

281.920.8004

May 9, 2005

Harris County Protective Services for Children and Adults
Attention: Mr. George Ford, Executive Director
2525 Murworth
Houston, Texas 77054

Dear Mr. Ford:

The Houston Independent School District: West District Youth and Family Center has partnered with multiple public and private organizations to provide school-based mental health services for the past seven years. As the Western Region Superintendent, I am pleased to support your organization's application for Substance Abuse and Mental Health Services Administration's (SAMSHA) funds to assist in the establishment of a county-wide coordinated system of care for children identified as seriously emotionally disturbed (SED).

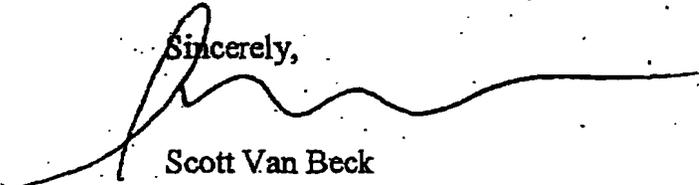
Many children and families residing in the Western Administrative Region of the Houston Independent School District receive limited or no mental health services due to lack of resources and limited coordination. The HISD West District Youth and Family Center (YFC) has traditionally been a source of mental health services for students and their families, but in FY 2002 - 2003 YFC funds for contract counseling were reduced by 31% from the previous year and HISD lost 5 Ph.D. psychologist positions due to mandatory budget cuts. In 2003 - 2004 an additional psychologist position and post-doctoral trainee position were eliminated in HISD due to additional mandatory cuts. Due to the severity in the need for services, HISD re-opened two psychologist positions in 2004 - 2005. Although the YFC maintained its FY 2002 - 2003 level of funding for contract counseling in 2003 - 2004 those funds were reduced by 38% for 2004 - 2005. There is currently a net loss of 5 psychology positions in HISD and YFC funding for contract counseling is down 43% from FY 2001 - 2002 with the possibility of further major cuts for the coming year. In addition, the Mental Health and Mental Retardation Authority of Harris County (MHMRA) psychiatric services provided at the YFC have been reduced from 3.5 hours per week to 3.5 hours twice a month.

As a result of these losses and the increased need, it is critical that the HISD West District Youth and Family Center and other groups continue to work with organizations such as MHMRA, DePelchin Children's Center, Harris County Protective Services for Children

and Adults, University of Texas Harris County Psychiatric Center, and the Mental Health Association. My staff has been instrumental in participating in strategic planning, grant coordination and other activities designed to improve access to and resources for child and adolescent mental health services in Harris County. In furtherance of this effort, I support the continued participation of Western Region staff member, Dr. Grace Jennings, Psychologist in the effort to develop and expand the system of care in our community.

Mr. Ford, please accept this letter as evidence of our pledge to your community-wide effort to make valuable systems change for youth with SED.

Sincerely,



Scott Van Beck
Western Region Superintendent

May 10, 2005

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Mr. George Ford, Executive Director
Harris County Protective Services for Children and Adults
2525 Murworth
Houston, Texas 77054

Dear Mr. Ford:

ChildBuilders has been providing mental health advocacy services to the residents of Harris County for over 31 years. As President of the Board of Directors, I am pleased to offer the support of this agency to the Harris County Alliance for Children and Families: Mental Health Project (HCA) to make effective mental health services systems change for our community's children who are identified as seriously emotionally disturbed (SED).

ChildBuilders is very interested in serving as the agency that supports the state and local liaison for the 2006 SAMHSA proposal ("Cooperative Mental Health Agreements for Children and Families"). The ChildBuilders state and local liaison will serve as the bridge between the State and Harris County in an effort to create a single system of care that will be sustained through collaborative and integrated funding investments from State and/or community-based, child-and family-serving public agencies. Efforts include working to establish interagency involvement in the project's structure and process by developing and/or changing interagency agreements and other public policies relevant to the creation of the system of care.

ChildBuilders' 31-year history as an advocate for children's mental health makes us the ideal agency to staff this position. We are able to offer an in-kind match of office space, equipment, insurance, materials, etc. totaling \$17,162.87. The cost allocated to the grant for the position will be salary for a 30 hour per week position and benefits totaling \$37,200.

ChildBuilders' Mission Statement

ChildBuilders provides innovative ChildBuilders provides innovative services, programs, education, and collaboration to promote healthy child and family development. We have established strong collaborative ties with the Family-Centered Child Care Collaborative, Houston Independent School District, and others. ChildBuilders is known to representatives and senators in the Texas Legislature for our advocacy efforts including our leadership in the statewide Children's Advocacy Day.

ChildBuilders' Advocacy Committee

The mission of ChildBuilders' Advocacy Committee is to actively engage various stakeholders, in partnership with other organizations where appropriate, to advocate for the interests of children's mental health.

Dr. Mary Lewis chairs our very active Advocacy Committee. Dr. Lewis has a 25-year tenure as professor of social policy and social research with the University of Houston Graduate School of Social Work. She works directly with the M.S.W. and Ph.D.

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Celebrating 30 years of promoting healthy child and family development

3800 Buffalo Speedway Suite 310 Houston, TX 77098 713/400-1155 Fax 713/400-1156 www.childbuilders.org

degree programs, and is a strong advocate for issues pertaining to children's mental health.

ChildBuilders' Programs

ChildBuilders (formerly known as Houston's Advocates for Mental Health in Children) is a 501(c)3 nonprofit organization entering its 31st year of service. ChildBuilders fills a valuable niche in promoting mentally healthy child and family development through our children's mental health *Community Education Program* (focused on advocacy and the distribution of parent education materials), the *Family-Centered Child Care Collaborative* (a collaboration with nine nonprofit organizations to strengthen child care centers and increase parental involvement and services), *Parents Under Construction* (a program that teaches children today the parenting skills they need for the future), and *WHO* (We Help Ourselves – a child abuse and anti-victimization education program).

Harris County Alliance for Children and Families: Mental Health Project (HCA)

For the last ten years through various partnerships, many agencies and organizations have been coordinating mental health and other needs to better effectuate services provided through the respective partners. However, despite best efforts, some youth continue to receive disjointed services with and little or no aftercare services once they are no longer agency involved. Other youth are never identified or receive no mental health services at all. HCA has begun the process to combine small existing efforts into one local unified inter-agency system of care designed to improve services for youth. HCA proposes to streamline service coordination that will include eliminating barriers to information sharing, integrating information systems, training current and future practitioners in systems of care, enhancing family-focused services, and including youth and families at every level including the Governing Board.

ChildBuilders is committed to making changes to provide comprehensive mental health services to SED youth in Harris County. As evidence of my agency's commitment to this endeavor, I have agreed to serve as a member of the HCA Governing Board. In addition, ChildBuilders will work with HCA to expand and improve our system of care to serve as model for other counties in the state of Texas.

Mr. Ford, please accept this letter as confirmation of our commitment to the Harris County Alliance for Children and Families: Mental Health Project's effort to make valuable systems change for youth with SED. If you have any questions concerning this letter, feel free to contact me at 713-400-1155.

Sincerely,



Dorothy Matthews, Ph.D.
President, Board of Directors



TEXAS HEALTH AND HUMAN SERVICES COMMISSION

May 6, 2005

ALBERT HAWKINS
EXECUTIVE COMMISSIONER

Mr. George Ford,
Executive Director
Harris County Protective Services
for Children and Adults
2525 Murworth
Houston, TX 77054

Dear Mr. Ford:

On behalf of the Texas Integrated Funding Initiative (TIFI) Consortium, we would like to extend our support to the Harris County Alliance for Children and Families, for their submission of the *Child Mental Health Initiative* grant proposal to the Substance Abuse and Mental Health Services Administration, United States Department of Health and Human Services. The Texas Health and Human Services Commission implemented the Texas Integrated Funding Initiative in 1996 through funding support from the Robert Wood Johnson Foundation and the Texas Department of Mental Health and Mental Retardation. In 1999, legislation directed the Health and Human Services Commission to form a consortium with representation from:

- Department of State Health Services (includes legacy agencies Texas Department of Mental Health and Mental Retardation and the Texas Council on Alcohol and Drug Abuse);
- Department of Family and Protective Services;
- Texas Education Agency;
- Texas Juvenile Probation Commission;
- Texas Youth Commission; and
- An equal number of family and/or youth members.

The TIFI Consortium is legislatively charged to provide oversight to "develop local mental health care systems in communities for minors who are receiving residential mental health services or who are at risk of residential placement."

Harris County has been a demonstration site and community partner to TIFI since September 2000. During this timeframe, Harris County has shown success in implementing components of a system of care approach to service delivery with support and assistance from small state grant funds (ranging annually from \$75,000 in the past years to \$40,000 at present) targeting a specific

Mr. George Ford
May 6, 2005
Page 2

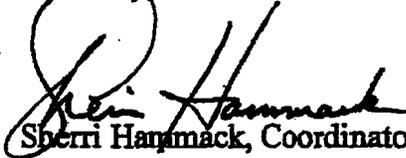
school district population of children with severe emotional disturbances. Through the collective leadership of public agencies, private organization, and family representatives, this community has utilized TIFI to build upon the success of the Harris County Triad Program and the local Community Resource Coordination Group to unite the three programs into the Harris County Alliance for Children and Families (Alliance). This Alliance has provided a more streamlined single point of access to services for children, youth and their families with multi-agency needs. The children and youth served through these collaborative efforts have benefited by improved school attendance, decreased suspensions, improved behavior at school, and overall improvement in school functioning. Through TIFI, the Alliance has also leveraged family-driven activities including the development of informal support services, family training, and service coordination with care coordinators. As a result, these collaborative service delivery approaches have been broadened to other parts of the county through outreach efforts from the initial targeted school-based site.

Based on the successful work of the Alliance through TIFI, there has been a demonstrated capacity within this community to develop a system of care approach for children and youth with severe emotional disturbance and their families. An existing infrastructure is in place that should afford a stable foundation for continuing more broad-based, innovative system of care service delivery approaches, in conjunction with a strong component of pairing care coordinators with parent coordinators to guide the process. Additionally, plans to include family partners to develop system of care training programs to educate incoming professionals (for example, the School of Social Work at the University of Houston, Rice University, and Baylor College of Medicine, among others) will prove effective in implementing system of care practices.

Therefore, as evidenced by the noted examples above, the state-level TIFI Consortium endorses the grant proposal of the Harris County Alliance for Children and Families.

Please feel free to contact me if you have any questions or need additional information. I can be reached at (512) 424-6964 or by e-mail at sherri.hammack@hhsc.state.tx.us.

Sincerely,



Sherri Hammack, Coordinator

Texas Integrated Funding Initiative Consortium
Office of Program Coordination for Children and Youth
Office of Health Services Division

SH:cm

CAPITOL OFFICE ROOM E2.610
P.O. BOX 2910
AUSTIN, TEXAS 78768-2910
(12) 463-0734
(12) 479-6955 FAX



DISTRICT OFFICE
1350 NASA PARKWAY, SUITE 212
HOUSTON, TEXAS 77058
(281) 333-1350
FAX: (281) 335-9101

JOHN E. DAVIS
STATE REPRESENTATIVE
DISTRICT 129

May 4, 2005

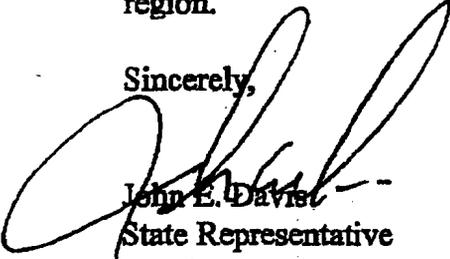
Mr. George Ford, Executive Director
Harris County Protective Services
2525 Murworth Drive
Houston, Texas 77054

Dear Mr. Ford:

Please accept this letter of support to Harris County Protective Services for Children and Adults in your request for funding from the federal Substance Abuse and Mental Health Services Administration. The SAMHSA Grant Proposal of \$9 million for six years would greatly assist Harris County to expand the systems of care for children with severe emotional disturbances and their families within the county. This funding would assist Harris County with its ongoing collaborative effort among several child serving agencies such as Harris County Juvenile Probation Department and the Mental Health and Mental Retardation Authority of Harris County.

Harris County continues to meet the challenges of the children and adults in the ever growing Houston area. I support your request to SAMHSA to continue and expand your services to this region.

Sincerely,


John E. Davis
State Representative
District 129



3
COMMITTEES: APPROPRIATIONS • HUMAN SERVICES; CHAIRMAN, BUDGET & OVERSIGHT • HOUSE ADMINISTRATION

EMAIL: JOHN.DAVIS@HOUSE.STATE.TX.US

HTTP://WWW.HOUSE.STATE.TX.US
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The State of Texas

Committees
Nominations, Chair
Health and Human Services
Infrastructure Development
and Security
Natural Resources

JON LINDSAY
District 7

April 29, 2005

Mr. George Ford
Executive Director
Harris County Protective Services
2525 Murworth Dr.
Houston, Texas 77054

Dear Mr. Ford:

I would like to express my support for Harris County Protective Services collaborative effort along with several child serving agencies such as Harris County Juvenile Probation Department and Mental Health and Mental Retardation Authority of Harris County to pursue the federal SAMHSA grant. I know you will agree with me that this proposal certainly has merit given the current limited availability of children's mental health services in many areas of the state.

Tight budgets, within both private and public health care programs, can cause mental health benefits to be reduced or drastically pared back so money can be diverted to other health care coverage. I believe, as state officials, we should encourage local innovation and initiative to address gaps in the state's existing mental health care system.

The system will be directed to provide the necessary elements that allow children assessed with serious mental or emotional disturbance to stay within family units and in the least restrictive environment possible. I applaud the effort of Alliance for Children and Families, and am hopeful that they will be able to put this rather ambitious and creative project into action with the help of the federal grant proposal SAMHSA.

Again, I ask for support for this proposal and approval of the Alliance for Children and Families request for federal SAMHSA grant monies.

Sincerely yours,

Jon Lindsay
JON LINDSAY
State Senator
JL/zh

Congress of the United States
House of Representatives

Washington, DC 20515-4322
April 28, 2005

Mr. George Ford
Executive Director
Harris County Protective Services
2525 Murworth Drive
Houston, Texas 77054

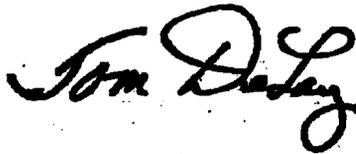
Dear Mr. Ford:

Thank you for your letter in regarding the Harris County Alliance for Children and Families' grant application made to the Substance Abuse and Mental Health Services Administration.

I am happy to contact Administrator Charles Curie on your behalf. Specifically, I have encouraged him to carefully review the application and give it every consideration possible. I am committed to ensuring that the application for this grant receives a fair and thorough review.

Thank you again for contacting me.

Sincerely,



Tom DeLay
Member of Congress

TD:hh



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INTERNATIONAL RELATIONS
TRANSPORTATION
SMALL BUSINESS

DISTRICT OFFICE
20202 U.S. Highway 29 North
Suite 100
HUMBLE, TX 77338
PHONE: (281) 448-0242
FAX: (281) 448-0252

Congress of the United States
House of Representatives
Washington, DC 20515-4302

May 11, 2005

Mr. Mike Leavitt
Secretary
The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Leavitt:

As the U.S. Representative for Texas' 2nd District, I urge the Department of Health and Human Services (HHS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) to consider the request to provide \$9 million in funding for six years to the Harris County Protective Services for Children and Adults (HCPS). These funds would be used to expand the systems of care for children with severe emotional disturbances and their families in Harris County.

As a felony court judge in Harris County for 22 years, I presided over more than twenty-five thousand cases. I have worked extensively with HCPS, witnessing their service to our community firsthand. The growing population of Harris County creates a critical need for increased funding to systems of care. Providing the \$9 million in funding to HCPS will significantly strengthen their ability to serve those who might otherwise fall through the cracks.

HCPS has an extensive history of partnering with multiple agencies in addressing health, educational, vocational and social service issues. Due to the varying requirements of each agency, the information about each case is often spread across multiple databases. The requested funding would help HCPS strengthen the relationships between the agencies and integrate the multiple information systems. The funding would also be used, through training and evaluation, to address system changes and adapt to the changing needs of families receiving services. The end result would be higher quality care for children with severe emotional disturbances and their families.

Thank you for your consideration of this important matter. If you have any questions, please do not hesitate to contact me.

God and Texas,

Judge Ted Poe
Member of Congress

May 3, 2005

George Ford, J.D.
Executive Director
Harris County Protective Services
For Children and Adults
2525 Murworth
Houston, TX 77054

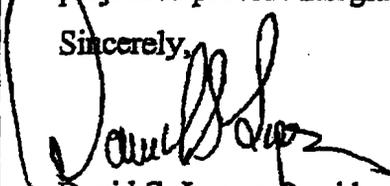
Dear Mr. Ford:

On behalf of the Harris County Hospital District, I am pleased to offer support to the Alliance for Children and Families of Harris County in their application to the Substance Abuse and Mental Health Services Administration for the Child Mental Health Initiative 2005. Our current service delivery system for children with serious emotional disturbance (SED) is extremely fragmented and presents multiple barriers to service access for these children and their families. The plan proposed by the Alliance for Children and Families of Harris County will develop a cohesive, coordinated, local system of care that "wraps around" each family's unique strengths, challenges, and goals to address this pressing need.

The Hospital District will send a representative and participate on the proposed Governing Board during the first year and work with other community agencies to develop the integration plan for Harris County and participate in the implementation of the plan. We will continue to facilitate eligibility for Hospital District services for children with SED seen in the local system of care.

I strongly encourage favorable consideration of this grant application and look forward to working with Harris County Protective Services, the Alliance, and other community organizations on this worthwhile project to provide integrated services for children with SED.

Sincerely,



David S. Lopez, President/CEO
Harris County Hospital District

JOINT CITY/COUNTY COMMISSION ON CHILDREN
900 Bagby, 2nd Floor * Houston, TX 77002 * Phone: 713.247.1386 * Fax: 713.247.2683

April 28, 2005

Catherine Clark Mosbacher
Chair

Janice Marie Beal, Ed.D.

Rogene Gee Calvert

Im Colby, Ph.D.

Honorable Garnet Coleman

Honorable Ruben Davis

Honorable Robert Eckels

Honorable Ada Edwards

Felix Fraga

Bobbie Henderson, Ph.D.

Ann Kaufman

Robert Kendrick, Ph.D.

Omwale Lauli-Allen

Linda McNell, Ph.D.

Rosie Valadez, McStay

Greg Meyers

Jileen Merinoto

Steven Papadopoulos

Michelle Sabino, Ed.D.

John E. Sawyer, Ed.D.

Steve Schmalz, Ph.D.

John Sparks, M.D.

Janet Stansbury

Elaine Stolte

Jonathan Day
Immediate Past Chair

Shera McKenzie

Harris County Protective Services for Children and Adults
Attention: Mr. George Ford, Executive Director
2525 Murworth
Houston, Texas 77054

Dear Mr. Ford:

The Joint City/County Commission on Children's (JCCCC) mission is to generate an action plan advocating for children under 18; assess the general welfare of our community's children; and promote the healthy development of youth in the City of Houston and Harris County. For that reason, the JCCC is proud to support the Harris County Protective Services for Children and Adults' (HCPS) collaborative effort with local child-serving organizations to implement and expand community-based services for children with serious emotional disturbance (SED) through the Substance Abuse and Mental Health Services Administration's grant program titled, "*Children's Mental Health Initiative*".

Harris County has more than 980,000 children under 18. Approximately 20% of children in the county live in poverty and 25% are uninsured. Stagnant budgets and reductions in mental health funding have limited enrollment in the state's Children's Health Insurance Plan (CHIP) and for children with mental health needs, insurance is critical. An estimated 5% or 49,000 children in Harris County are living with SED and there is no single comprehensive strategy or the funds to provide community-based services for such a large population. It is our vision as a community that developing a single comprehensive community-based, family-driven and culturally competent system of care will ensure children with SED develop to their full potential.

Please accept this letter of support as evidence of our commitment to your agency and the community's effort to provide children with the mental health treatment and support necessary to achieve developmental milestones.

Sincerely,



Catherine C. Mosbacher
Chair

Joint City/County Commission on Children



DePelchin
Children's Center

Serving Children & Families Since 1892

May 9, 2005

Mr. George Ford, Executive Director
Harris County Protective Services for Children and Adults
2525 Murworth
Houston, Texas 77054

Dear Mr. Ford:

DePelchin Children's Center has been providing mental health and child welfare services to the residents of Harris County for over 112 years. As President and Chief Executive Officer, I am pleased to offer the support of this agency to the Harris County Alliance for Children and Families: Mental Health Project (HCA) to make effective mental health services systems change for our community's children who are identified as seriously emotionally disturbed (SED).

For the last ten years through various partnerships, many agencies and organizations have been coordinating mental health and other needs to improve services provided through the respective partners. However, for the seriously emotionally disturbed children, services are often disjointed and lacking. The intent and philosophy underpinning this comprehensive community mental health services initiative for children and their families is long overdue. HCA proposes to streamline service coordination that will include eliminating barriers to information sharing, integrating information systems, training current and future practitioners in systems of care, enhancing family-focused services, and including youth and families at every level including the Governing Board.

DePelchin Children's Center is committed to making changes to provide comprehensive mental health services to targeted youth in the county with SED. As evidence of my agency's commitment to this endeavor, I, Curtis C. Mooney, Ph.D. President/CEO or my designee have agreed to serve as a member of the HCA Advisory Committee to the Alliance Governing Board. In addition, DePelchin Children's Center will work with HCA to expand and improve our system of care to serve as a model for other counties in the state of Texas. To that end, I commit the organization to the following:

Contribution	Estimated Value (In-Kind)
▪ Use of 4,000 sq.ft. training facility for 8 days of training each year (\$500/per day x 8 days)	\$4,000.00
▪ Use of training center for video conferencing/training meetings each year (4 sessions x \$250)	\$1,000.00
▪ Office space, telephone, and computer with internet access and office supplies for Care Coordinator	\$3,500.00
▪ 1 Licensed Clinical Therapist (to be named) to attend train the trainer sessions in evidence-based practices (\$/hr with fringe x40 hours)	\$2,800.00

50 Memorial Drive
Houston, Texas 77007
Phone: 713.730.2335
www.depelchin.org

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A United Way Agency

Member, Child Welfare League of America
Member, Alliance for Children and Families

DePelchin Children's Center is an authorized Medicaid provider for mental health services and contracts with numerous Managed Care Organizations. We will be happy to accept referrals from the Alliance for children and families with these payor sources.

Further, DePelchin has an experienced research team that would provide contracted services to assist with the required evaluation components of this project. Jane Harding, Ph.D. and Jeannette Truxillo, Ph.D. have designed the organizational, systemic, and child and family evaluation component and will be providing process monitoring and evaluation to the project directors. Our agency has been involved in program evaluation for the past 18 years and has had experience in designing and implementing program and process evaluation with multi-site projects and collaborative projects in the areas of child abuse prevention and homeless youth for the past ten years.

Please accept this letter as confirmation of our commitment to the Harris County Alliance for Children and Families: Mental Health Project's effort to make valuable systems change for youth with SED. If you have any questions concerning this letter, feel free to contact me at the above-mentioned telephone number and address.

Sincerely,



Curtis C. Mooney, Ph.D., LMSW
President & CEO



Stuart C. Yudofsky, M.D.

One Baylor Plaza, BCM 350
Houston, Texas 77030
TEL: (713) 798-4945
FAX: (713) 796-1615
E-mail: stuarty@bcm.tmc.edu

D.C. and Irene Ellwood
Professor and Chairman
Menninger Department of Psychiatry
and Behavioral Sciences

Chief,
Psychiatry Service

May 5, 2005

George Ford, Executive Director
Harris County protective Services
For Children and Adults
2525 Murworth
Houston, TX77054

Dear Mr. Ford:

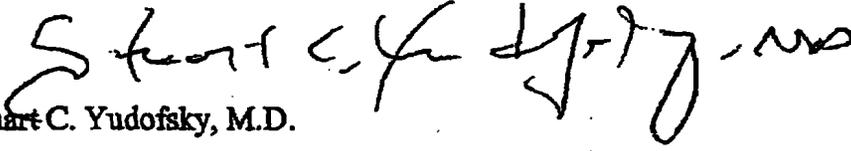
I am extremely pleased to offer the strong support of the Baylor College of Medicine Menninger Department of Psychiatry and Behavioral Sciences for the Harris County Child Mental Health Alliance Community System of care for seriously emotionally disturbed children and adolescents described in the accompanying program application. Harris County is a large, populous and culturally diverse area. Our Department has a long history of providing mental health services for children and adolescents and training physicians in child and adolescent psychiatry and psychologists in child mental health. We recognize the need to develop an integrated community based system of care for seriously troubled youth in our community, and to train the next generation of mental health professionals to work such a treatment system. We pledge that all trainees in our Department will learn the principles of community systems of care and that clinical training rotations in this system will be available for all trainees in both psychiatry and psychology.

The Department of Psychiatry also supports a member of our senior faculty, Dr. John Sargent, Professor of Psychiatry and Pediatrics to act as the Clinical Director of Harris County Alliance community system of care. Dr. Sargent is an exceptional choice for this role. He is an outstanding clinician, a clinical leader and an experienced and nationally renowned educator in child mental health. He has experience in a wide variety of clinical settings and has worked for over 25 years to build systems of care for emotionally disturbed youth locally, nationally and internationally. Dr. Sargent also has developed excellent working relationships with leaders of the other agencies and institutions participating in this application and in the systems of care. Dr. Sargent's participation in this project represents a significant asset for our community's application and connects our Department's clinical, education and research missions with a significant advance in the treatment of our community's troubled children and adolescents.

I am most happy to pledge the full cooperation of our Department with this application our firm belief that this project will represent a major advance in the organization and delivery of mental health care for trouble youth in Harris County. I pledge that I will serve on the Advisory Board

for the Alliance. Our community needs to pursue this effort, the community is prepared to carry out the program with excellence and the Baylor College of Medicine Menninger Department of Psychiatry and Behavioral Sciences is pleased to play a major role in this important innovation.

Yours sincerely,

A handwritten signature in black ink, appearing to read "Stuart C. Yudofsky, M.D.", written in a cursive style.

Stuart C. Yudofsky, M.D.

May 13, 2005

Harris County Protective Services for Children and Adults
Attention: Mr. George Ford, Executive Director
2525 Murworth
Houston, Texas 77054

Dear Mr. Ford:

As Director of Youth and Adolescent Services, I am pleased to offer the support of The Council on Alcohol and Drugs Houston (The Council) to the Harris County Protective Services for Children and Adults' (HCPS) application for funding to the Substance Abuse and Mental Health Services Administration to improve the systems of care for youth identified as seriously emotionally disturbed (SED) in Harris County. The Council provides substance abuse prevention, intervention, treatment, and education services to Harris County children, adolescents and adults. The Council has served greater Houston families since 1946, providing a diverse array of services that are vital to this community. The Council is enthusiastic about every opportunity to improve the quality of life for the children of Harris County.

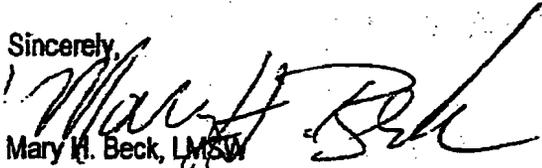
Children with SED and their parents need an integrated system of care, which is comprised of a broad array of services, including substance abuse prevention and treatment. Coordinated efforts between public and community-based organizations are essential to effectively coordinate services and leverage funding. Limited funding for public entities working with children with SED often prohibits the use of best practices and the utilization of ancillary services such as mentoring, youth enrichment activities and respite care. Partnerships with community-based organizations help with the provision of these needed ancillary services

The Council's relationship with HCPS and other County programs began more than two decades ago and has grown to be strong and valuable to the youth in our community. Annually, over 3,800 students participate in The Council's school- and community-based prevention programs. Despite this large number of students receiving services, the number of children in need of substance abuse services is great.

In an effort to assist HCPS and community partners in improving the system of care for children with SED, The Council will continue to conduct presentations regarding alcohol, tobacco and other drugs; substance abuse; addiction and recovery; prevention and treatment; Council history and services; or related topics, to any school, organization or community group in the Harris County. Upon request and through a mutual agreement, Council staff also can offer training to professionals in the system of care. Through the Prevention Resource Center, The Council can provide free pamphlets and brochures or loan out videos and books related to these topics. In addition, The Council will send an agency representative to serve on the Governing Board and participate in any training initiatives designed to improve and expand the system of care.

The Council looks forward to working with HCPS and its partners on this endeavor and wishes your organization success on this application for funding.

Sincerely,


Mary K. Beck, LMSW
Director, Youth and Adolescent Services

**MEMORANDUM OF UNDERSTANDING
FOR THE COORDINATION OF MENTAL HEALTH SERVICES
BETWEEN THE TRAI AGENCIES
FOR
THE HARRIS COUNTY ALLIANCE FOR CHILDREN AND FAMILIES: MENTAL
HEALTH PROJECT**

PURPOSE

In 1974, the Harris County Children's Protective Services (now known as Harris County Protective Services for Children and Adults, CPS), the Harris County Juvenile Probation Department (HCJPD) and the Mental Health and Mental Retardation Authority of Harris County (MHMRA) approached the Harris County Commissioners' Court for funding to develop programs and residential services for at-risk youth in Harris County. Funding was granted and the alliance between the agencies has become known as "TRIAD". Although TRIAD is not a legal entity in itself, it is a consortium of three county agencies working with the community to coordinate services by the most efficient means to provide comprehensive intervention, prevention and support services to the youth and families.

PLEDGE

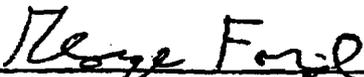
In furtherance of the efforts by the Harris County Alliance for Children and Families (Harris County Alliance) to improve the system of care for youth living with serious emotional disturbances (SED) through a public/private multi-agency interdisciplinary approach, the TRIAD agencies of Harris County have agreed to the following:

1. Agree to deliver and/or coordinate the required mental health services and supports with public and private providers who administer those services in accordance with Federal entitlements that may include: Medicaid, State Children's Health Improvement Program (S-CHIP), Title IV-B (Child Welfare/Family Preservation and Support Services), Title IV-E (Foster Care, Adoption and Independent Living), and Individuals with Disabilities Education Act (IDEA).
2. Utilize, coordinate and partner with public and private agencies that have received other Federal discretionary grant funds that may include: the Minority Substance Abuse Prevention and HIV Prevention Services Program Grant (CSAP), the National Child Traumatic Stress Initiative Grant (CMHS), and the Youth Violence Prevention (CMHS) from the Substance Abuse and Mental Health Services Administration (SAMHSA).
3. Authorize CPS to serve as the administering agency of TRIAD and authorize the CPS Executive Director to serve as the Principal Investigator for the Harris County Alliance for Children and Families: Mental Health Project.
4. Agree to serve on the Governing Board with other child-serving agencies, youth and parents to make effective changes in the system of care.
5. Create a child-centered and family-focused strategic plan for youth that embraces community-based culturally competent services and supports.

6. **Implement and enforce**, Memorandums of Understanding with other child-serving agencies and organizations and work to eliminate barriers in service integration through procedure and policy changes.
7. **Develop** mechanisms for managing, coordinating, and evaluating program strategies and services.
6. **Hire** Project Director to oversee the implementation of the system of care strategic plan and work with key staff to make effective changes at the local and state level.
7. **Improve and strengthen** relationships with other child-serving agencies in Harris County.
8. **Subscribe** to interdisciplinary training initiatives and values for all participants in the **Harris County Alliance**.
9. **Provide** support staff along with other partners in furtherance of these efforts.

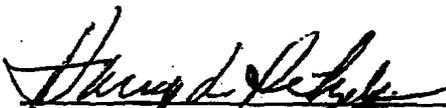
AFFIRMATION

We, the Executive Directors of the TRAIID agencies have signed below to verify our commitment to making effective changes in the system of care for youth with SED to provide comprehensive seamless mental health and social services.



 George Ford, HC Protective Services

Date 5/13/05



 Harvey L. Hetzel, HC Juvenile Probation Dept.

Date 5/13/05



 Steve Schnee, Ph.D, Executive Director
 Harris County Mental Health Mental Retardation
 Authority

Date 5/13/05



Appendix 2:
Governor's Assurance



TEXAS DEPARTMENT OF STATE HEALTH SERVICES

EDUARDO J. SANCHEZ, M.D., M.P.H.
COMMISSIONER

1100 W. 49th Street • Austin, Texas 78756
1-888-963-7111 • <http://www.dshs.state.tx.us>

May 9, 2005

Diane L. Sondheim
Deputy Chief
Child, Adolescent and Family Branch
Division of Service and System Improvement
1 Choke Cherry Road, Room 6-1043
Rockville, Maryland 20857

RE: Governor's Letter of Assurance for Harris County, Texas application for
SAMHSA Child Mental Health Initiative (SM-05-010) for FY 2005-06

Ms. Sondheim:

This is to verify that the Texas Department of State Health Services has been designated by the office of Texas Governor Rick Perry to be the agency with all assurance and signatory authority pertaining to the SAMHSA Cooperative Agreement for Comprehensive Community Mental Health Services for Children and their Families program.

It is understood that Harris County, Texas, is an applicant for SAMHSA Child Mental Health Initiative funds for fiscal year 2005-06, and will continue to seek funding through FY 2011 (a 6 year cooperative agreement). The lead agency and fiscal agent is Harris County Protective Services for Children and Adults (HCPS). The HCPS TRIAD Prevention Program will administer the *Harris County Alliance for Children and Families*. The Alliance is a multi-agency and family collaborative serving the function of the state-mandated Community Resource Coordination Group (CRCG) in order to coordinate and facilitate services and supports to children with special needs involved with multiple youth service agencies. The Alliance will provide local leadership in developing a system of care whose goal is to transform the delivery of mental health services to Texas children and youth with severe emotional disturbances (SED) and their families.

Services required in this cooperative agreement are covered in the State Medicaid Plan. The State of Texas have entered into participatory agreements under the State plan with Harris County Juvenile Probation Department, Mental Health Mental Retardation Authority of Harris County, and Harris County Protective Services to provide direct services required in the SAMHSA cooperative agreement. These agencies are qualified to receive payments under the State Medicaid Plan. All other designated and participating service providers will be required to enter into a participation agreement under the State Medicaid Plan and will be qualified to receive Texas Medicaid payments.

An Equal Employment Opportunity Employer

The vision and goals of *Harris County Alliance for Children and Families* system of care proposed under this Request for Applications are specifically included in the goals of the Texas Community Mental Health Services Block Grant Plan, as authorized in Section 564 (b) of the HCS Act, and in the Texas Mental Health Plan for Children and Adolescents with Serious Emotional Disturbances, submitted under Public Law (PL) 102-321. The Alliance system of care is consistent with plans proposed under all SAMHSA-funded State Incentive Grant and/or State Infrastructure grants awarded to Texas.

The Texas Department of State Health Services supports the development and expansion of the Harris County Alliance for Children and Families system of care, and is committed to assist in cultivating the community and interagency partnerships necessary to build and sustain this system of care.

Sincerely,

Dave Wanser Ph.D.

Dave Wanser, Ph.D.
Deputy Commissioner, Behavioral and Community Health Services
Department of State Health Services

Appendix 3:
Data Collection Procedures and Instruments

In Year One we will be collecting data from children, youth, families, Alliance partners and service providers.

Data will be collected from families and community systems using all measures required by the National Evaluation and outlined in the SAMHSA RFP Appendix G, p. 67 and 68. We will conduct the following assessments and studies according to National Evaluation task and frequency of collection guidelines:

1. System of Care Assessment
2. Services and Costs Study
3. Cross-sectional Descriptive Study
4. Longitudinal Child and Family Outcome Study
5. Service Experience Study
6. Sustainability Study
7. Monthly Evaluation Activity Report

In addition, we will use the following instruments to collect data for our local evaluation component:

1. HIFI Family and Child Intake form
2. Collaboration Survey created by DePelchin Children's Survey re: follow-up attrition
3. Wraparound Fidelity Index 3.0 (only the caregiver form is included but we will utilize all versions in our local evaluation).
4. Promoting Cultural Diversity and Cultural Competency Self-Assessment Checklist for Personnel Providing Services and Supports to Children with Disabilities and Special Health Needs and Their Families.
5. Checklist to Facilitate the Development of Linguistic Competence within Primary Health Care Organizations
6. Checklist to Facilitate the Development of Policies, Structures and Partnerships That Support a Culturally Competent Research Agenda in Primary Health Care.
7. Checklist to Facilitate Cultural Competence in Community Engagement
8. Checklist to Facilitate the Development of Culturally and Linguistically Competent Primary Health Care Policies and Structures
9. Sustainability Self-Assessment Tool

Also note the timeline evaluation chart: Follow-up Study Attrition Projection.

HARRIS COUNTY INTEGRATED FUNDING INITIATIVE

Date of Referral _____

I. Student Information

Student's Name: _____
Last Name First Name Middle Name

Student's Address: _____
Street Number or P.O. Box Street Name Zip Code

Student's Phone Number: () - - - - - Student's DOB: / / - - - - -

Student's Social Security #: - - - - - Student's Medicaid #: - - - - -

Student's Gender: Male Female

Ethnicity: Asian American Black American European American Hispanic American
 Hispanic Surname (non-Hispanic) Native American Other

Custody: Both Parents Mother Father Guardian (relative)
 Guardian (non-relative) Ward of State Other

II. Parent/Guardian Information

Mother's Name: _____
Last Name First Name Middle Name

Mother's Address: _____
Street Number or P.O. Box Street Name Zip Code

Mother's Phone Number: () - - - - - Mother's Social Security #: - - - - -

Father's Name: _____
Last Name First Name Middle Name

Father's Address: _____
Street Number or P.O. Box Street Name Zip Code

Father's Phone Number: Number: () - - - - - Father's Social Security #: - - - - -

III. Person Whom Student is living:

Name: _____
Last Name First Name Middle Name

Relationship: _____

Address: _____
Street Number or P.O. Box Street Name Zip Code

Phone Number: () - - - - -

IV. School Placement

Current School Placement: _____

Address: _____ Phone Number: () - - - - -

School Contact: _____ Phone Number: () - - - - -

Current Instructor: _____ Phone Number: () - - - - -

Home School: _____

Special Education Placement: None Emotionally Disturbed Learning Disability
Speech/Language Impairment Other Health Impaired

V. DSM IV Diagnoses:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____

Form Completed By: _____ Title: _____

Agency: _____

Date Completed: _____

**COLLABORATION SURVEY – DRAFT ONLY – NOT FOR PUBLICATION OR DISTRIBUTION
WITHOUT PERMISSION FROM DEPELCHIN CHILDREN'S CENTER**

(constructs measured in red – are not on the surveys distributed to respondents)

Name of community group : _____ County : _____

The following instrument asks questions about your community group/collaboration and its members. The purpose of this instrument is to describe the composition of this collaboration, how the group functions, and other processes that occur within the collaboration. Please answer the survey to the best of your knowledge and in a way that reflects how you see the collaboration, not how you feel others would respond to the item. The survey will take approximately 15 minutes to complete. *Thank you in advance for your time and effort in completing this survey!*

I. Please Tell Us About Your Agency Or Who You Represent:

A. Who do you represent? (check the one that best describes who you represent)

Representation/Diversity

- | | |
|--|--------------------------------|
| _____ 1. Agency/Organization | _____ 3. Parent/citizen AND/OR |
| neighborhood/community representative | |
| _____ 2. Legal/Government-elected office | |

B. What is the classification of your agency/organization? (check the one that best describes who your agency/organization)

Representation/Diversity

- | | |
|---|---------------------------------------|
| _____ 1. School/academic | _____ 10. Police/crime prevention |
| _____ 2. Adult education (not parenting) | _____ 11. Housing assistance/shelter |
| _____ 3. Parenting education | _____ 12. Religious |
| _____ 4. Physical health | _____ 13. Government/legal |
| _____ 5. Mental health | _____ 14. Childhood |
| intervention/protection/advocacy | |
| _____ 6. Substance abuse | _____ 15. Adoption/foster care |
| _____ 7. Youth organization or club/rec. center | _____ 16. Small business development |
| _____ 8. Transportation | _____ 17. None, I am a |
| parent/consumer/concerned citizen | |
| _____ 9. Child care/day care | _____ 18. Other, please specify _____ |

II. Please Tell Us About Yourself And Your Role In The Collaboration:

A. How long have you participated in this collaborating group: _____ (in months)

B. Please select one of the following that best describes your role in the group: (check ONE) Role

- _____ 1. I take an active role by providing leadership, writing grants, and/or serving on subcommittees and steering committees.
(if yes, "Activist")
- _____ 2. I work on a limited basis on specific designated tasks such as letter writing, newsletter distributions, etc.
(if yes, "Helper")
- _____ 3. I communicate the work of the coalition to the outside through educational sessions and networks with other groups.
(if yes, "Communicator")

C. What kind of roles have you played during the past 12 months in the community group?
(Circle YES or NO for each item) Level of Commitment/Level of Participation

	Past 12 Months	
1. Attend meetings regularly	YES	NO
2. Talk at meetings (make comments, express ideas, etc.)	YES	NO
3. Serve as a member of a committee	YES	NO
4. Work for the community group outside of meetings	YES	NO
5. Help organize activities (other than meetings)	YES	NO
6. Direct the implementation of a particular program	YES	NO
7. Chair/lead a committee or sub-group	YES	NO
8. Service as an officer other than chair (e.g., treasurer, secretary)	YES	NO
9. Chair/co-chair the entire group	YES	NO

D. Please indicate your perceptions about the group by circling the number which best describes your position for each item.

Satisfaction	Never	Rarely	Sometimes	Mostly	Always
1. My viewpoint is heard.	1	2	3	4	5
2. I am viewed as a valued member.	1	2	3	4	5
3. I feel comfortable in the group.	1	2	3	4	5
4. I am satisfied with the group's progress.	1	2	3	4	5

III. Please Tell Us About This Collaborating Group:

A. Approximate date group initiated: _____ (mm/yy)

B. What is the collaboration's mission statement? (If you do not know the mission statement, what do you think it would be?)

C. Which of the following best describes your collaborating group: (check ONE) Functionality (Low to High)

- _____ 1. Members interact primarily for the purpose of exchanging information and communication.
- _____ 2. Members provide helpful resources to support each others' interests and goals; there is some joint planning and activity, but resources are separate.
- _____ 3. Members work together on complimentary goals; there is coordination and some sharing of resources.
- _____ 4. There is a formal structure for a group of agencies/organizations for a common purpose to be more efficient & effective.

IV. Group-Functioning:

Each of the following items deals with a factor that influences the collaboration process. After reading each item, please circle the response to the right that best reflects your opinion of how your collaboration is functioning in each of the areas.

(constructs are measured in red)

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. We have a shared and clearly understood vision. Shared Vision	1	2	3	4	5
2. We have goals and objectives. Goals & Objectives	1	2	3	4	5
3. We agree upon the goals and objectives. Goals & Objectives	1	2	3	4	5
4. The goals set by the collaboration describe situations or conditions that the collaboration thinks it can achieve. Success in Reaching Goals (1 - Believable)	1	2	3	4	5
5. The collaboration feels that the goals set can be achieved in a designated time. Success in Reaching Goals (2 - Attainable)	1	2	3	4	5
6. The goals set by the collaboration are capable of being understood and realized. Success in Reaching Goals (3 - Tangible)	1	2	3	4	5
7. The goals set allow all members of the collaboration to be successful. Success in Reaching Goals (4 - Win-win)	1	2	3	4	5
8. Each individual as well as each group in the collaboration understands and embraces the goals. (Success in Reaching Goals (5 - Acceptable)	1	2	3	4	5
9. Plans are well developed and followed. Action Plans	1	2	3	4	5
10. The collaboration has open and clear communication. Internal Communication	1	2	3	4	5
11. There is an established process for communicating between meetings. Internal Communication	1	2	3	4	5
12. There are membership guidelines relating to terms of office and replacement of members. Sustainability	1	2	3	4	5
13. The group is effective in making inter-organizational linkages. Resources	1	2	3	4	5
14. Members are clear about their roles. Responsibilities & Roles	1	2	3	4	5
15. Members trust each other. Relationship/Trust	1	2	3	4	5
16. The collaboration has changed policies, laws, and/or regulations that allow the collaboration to function effectively. Policies/Laws/Regulations	1	2	3	4	5
17. The history & environment surrounding power and decision-making is positive. Political Climate	1	2	3	4	5
18. We are able to manage conflict within the group successfully. Conflict Management	1	2	3	4	5
19. We have effective decision-making procedures. Decision-Making	1	2	3	4	5
20. Leadership is effective and shared when appropriate. Leadership	1	2	3	4	5
21. The leadership facilitates and supports team building. Leadership	1	2	3	4	5
22. The collaboration has conducted a needs assessment or has obtained information to establish its goals. Research & Evaluation	1	2	3	4	5

23. The collaboration continues to collect data to measure goal achievement. Research & Evaluation	1	2	3	4	5
24. We have built evaluation into all of our activities. Research & Evaluation	1	2	3	4	5
25. There is a communication system and formal information channels that permit the exploration of issues, goals, and objectives. External Communication	1	2	3	4	5
26. Our communication with the community is open and timely. External Communication	1	2	3	4	5
27. Our collaboration understands the community, including its people, cultures, values, and habits. Understanding Community	1	2	3	4	5

V. Collaboration Outcomes:

A. Listed below are various results that community groups may achieve that affect individuals, families, agencies, and the community in general. They may or may not be relevant to your community group depending upon the purpose of your group and how long you have been together.

For each item below, circle 1 if this is something that is not likely to be accomplished, circle 2 if this is something the group plans to work on in the future, circle 3 if the group is currently working on this, and circle 4 if your group has accomplished this already.

Circle N/A if this is something that does not apply to your group.

AS A RESULT OF OUR GROUP...

Impact of the group on others

	Not Likely	Plan to Work On	Working On	Has Been Done	Doesn't Apply
1. New group(s) have formed to address the need(s)/issue(s). Involvement of People	1	2	3	4	N/A
2. All key stakeholders and interests are represented. Involvement of People	1	2	3	4	N/A
3. Consumers/clients/beneficiaries are involved. Involvement of People	1	2	3	4	N/A
4. Community-wide awareness of the issue(s) has increased. Involvement of People	1	2	3	4	N/A
5. Planning has led to better targeting of services and programs. Planning	1	2	3	4	N/A
6. Agencies are better equipped to work collectively on community issues. Capacities	1	2	3	4	N/A
7. New/improved networks and relationships have been built among groups, agencies, and businesses. Networks	1	2	3	4	N/A
8. Resources are shared among groups/organizations. Resources	1	2	3	4	N/A
9. Services/programs have improved. Services and/or Programs	1	2	3	4	N/A

10. New services have been created. Services and/or Programs	1	2	3	4	N/A
11. Service delivery is more efficient. Services and/or Programs	1	2	3	4	N/A
12. Services/programs are more affordable. Services and/or Programs	1	2	3	4	N/A
13. Services/programs are more available. Services and/or Programs	1	2	3	4	N/A
14. Accessibility to services and programs has improved. Services and/or Programs	1	2	3	4	N/A
15. Underserved groups have increased their use of services. Services and/or Programs	1	2	3	4	N/A
16. There is less duplication of services in the community. Services and/or Programs	1	2	3	4	N/A
17. People are better off in our community. Conditions in our Community	1	2	3	4	N/A
18. There is an increased understanding of community needs. Conditions in our Community	1	2	3	4	N/A
19. People share a common direction for our community. Conditions in our Community	1	2	3	4	N/A

B. Please answer the following questions about what you think is the collaboration's impact on the community.

Feel free to write on the back if you need to.

1. Please indicate the extent to which you think your agency/organization has benefited by its participation in the collaboration:

- (check ONE) Benefit of Collaboration to Participating Agencies/Organizations
- No benefit yet
- Little benefit
- Moderate level of benefit
- Much benefit

2. Please indicate the extent to which you think the group has benefited your community overall: (check ONE)

- Benefit of Collaboration to the Community
- No benefit yet
- Little benefit
- Moderate level of benefit
- Much benefit

3. What do you think is the greatest impact that this community group has had on the community to date?
Impact

4. In your opinion, what could be done to improve the collaboration's effectiveness?

5. What do you think has been the collaboration's major contribution to the TFTS program thus far?

6. What do you think the collaboration could contribute to the program in the future?

Wraparound Fidelity Index 3.0

Caregiver Form



Youth's name: _____

Caregiver's name: _____

Resource facilitator's name: _____

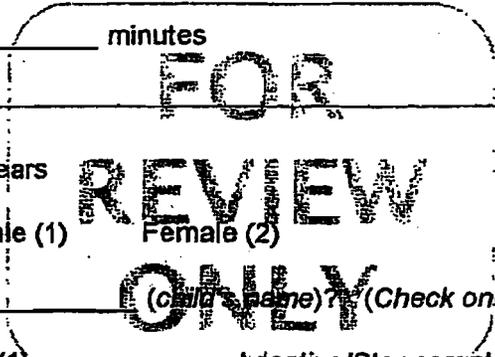
Interviewer's name: _____

Today's date: Month _____ Day _____ Year _____

Administration method: Face-to-face (1) Phone (2)

Length of interview _____ minutes

Youth ID:	
Caregiver ID:	
Resource facilitator ID:	
Interviewer ID:	
Project ID:	
Family ID:	
Timeframe:	



1. How old are you? _____ years

2. What is your gender? Male (1)

Female (2)

3. What is your relationship to _____ (child's name)? (Check one)

Biological parent (1)

Adoptive/Stepparent (2)

Foster parent (3)

Live-in partner of parent (4)

Sibling (5)

Aunt or uncle (6)

Grandparent (7)

Cousin (8)

Other family relative (9)

Friend (adult friend) (10)

Other (11) _____ (please specify)

4. Who has legal custody of _____ (child's name)? (Check one)

Two biological parents OR one biological parent and one stepparent (1)

Biological mother only (2)

Biological father only (3)

Adoptive parent(s) (4)

Foster parent(s) (5)

Sibling(s) (6)

Aunt and/or uncle (7)

Grandparent(s) (8)

Friend(s) (9)

Ward of the State (10)

Other (11) _____ (please specify)

Missing Data Codes: 666 Not Applicable; 777 Refused; 888 Don't Know; 999 Missing/Question Was Not Asked

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WFI 3.0-Caregiver

If biological parent has custody, go to question #5.

If biological parent does not have custody, read 4a.

4a. Is there a plan to reunite the youth with the biological parent? No (1) Yes (2)

If Yes, go to question #5.

If No, read 4b.

4b. What is the permanency plan for the youth?

5. Has your child ever been in the custody of the state? No (1) Yes (2)

6. Is he or she currently receiving Wraparound? No (1) Yes (2)

If Yes, Go to Question #7.

If No, Has your child received Wraparound in the past? No (1) Yes (2)

If No, go to Question #8.

If Yes, How many months did your child receive Wraparound? _____ months

Then go to Question #8

7. How many months has your child been receiving Wraparound? _____ months

8. Do you have a youth and family team? No (1) Yes (2)

If No, For the purposes of this interview, when we ask you about the team please consider the people that work with the youth and his or her family to provide services and supports.

If Yes, We will be asking questions about the team so keep those people in mind as you answer the following questions.

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Caregiver Form



I am going to ask you some questions about the services and supports your family is receiving now and for the past 30 days. For each question you can answer "Yes," "Sometimes" or "Somewhat," or "No." Please answer all questions as well as you can.

Element 1: Parent Voice and Choice	Yes	Sometimes Somewhat	No	Missing
A. Do you feel comfortable expressing your opinions even if they are different from the rest of the team?	2	1	0	666 777 888 999
B. Are important discussions or decisions about your child or family made when you are not there?	0	1	2	666 777 888 999
C. Do team members "overrule" your wishes regarding your child?	0	1	2	666 777 888 999
D. As the primary caregiver, are you given highest priority when making major decisions?	2	1	0	666 777 888 999

FOR

Element 2: Youth and Family Team	Yes	Sometimes Somewhat	No	Missing
<p>A. If caregiver is NOT youth's biological parent, but the biological parent has custody OR will be reunited with youth, ask: Do your child and one of her or his biological parents actively participate on the team?</p> <p>Otherwise ask: Do you and your child actively participate on the team?</p> <p>*Follow scoring rules.</p>	2	1	0	666 777 888 999
B. Is there a friend or advocate of your family who actively participates on the team?	2	1	0	666 777 888 999
C. Is there a representative from the school (or childcare provider) who actively participates on the team? *if youth is not supposed to be in school choose N/A or 666.	2	1	0	666 777 888 999
D. Does your team consist of people you want on the team?	2	1	0	666 777 888 999

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Element 3: Community-Based Services and Supports	Yes	Somewhat Applied	No	Missing																								
A. How many hours a week does your child spend... <div style="text-align: right; margin-right: 20px;"><i>Hours per week</i></div> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>1. at a regular community school?</p> <p>2. working at a paying job?</p> <p>3. in a job training program?</p> </div> <div style="width: 10%; border: 1px solid black; padding: 2px;"> <p style="text-align: center;">TOTAL =</p> </div> <div style="width: 40%; border: 1px solid black; padding: 2px;"> <p style="text-align: center;">_____</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">_____</p> </div> </div> <p style="font-size: small; margin-top: 5px;">*Total number of hours per week then score.</p>	2	1	0	666 777 888 999																								
	More than 20 total hours per week	10-20 total hours per week	Less than 10 total hours per week																									
B. Are the services and supports that your family needs hard to reach because they are far away?	0	1	2	666 777 888 999																								
C. Does the team help your child get involved with activities in your community? Please give two examples of those activities: <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">1. _____</div> <div style="border: 1px solid black; padding: 5px;">2. _____</div>	2	1	0	666 777 888 999																								
	Two examples of community activities.	One example of a community activity.	No examples of community activities.																									
D. Please tell me all the different places your child has lived in the past 30 days. Write down each living situation then ask: How many days did your child live in each situation? Write down the number of days for each living situation.	FOR REVIEW ONLY <i>Do not score this item until you have coded each living situation from the WFI User's Manual. This should be done after the interview is complete.</i>			666 777 888 999																								
<table border="1" style="width: 100%; border-collapse: collapse; font-size: x-small;"> <thead> <tr> <th style="width: 60%;">Living Situation</th> <th style="width: 15%;"># Days</th> <th style="width: 10%;">Code</th> </tr> </thead> <tbody> <tr><td>1. _____</td><td></td><td></td></tr> <tr><td>2. _____</td><td></td><td></td></tr> <tr><td>3. _____</td><td></td><td></td></tr> <tr><td>4. _____</td><td></td><td></td></tr> <tr><td>5. _____</td><td></td><td></td></tr> <tr><td>6. _____</td><td></td><td></td></tr> <tr> <td style="text-align: right; padding-right: 20px;">TOTAL =</td> <td style="border: 1px solid black; width: 50px; height: 20px;"></td> <td></td> </tr> </tbody> </table>	Living Situation	# Days	Code	1. _____			2. _____			3. _____			4. _____			5. _____			6. _____			TOTAL =			2	1	0	666 777 888 999
Living Situation	# Days	Code																										
1. _____																												
2. _____																												
3. _____																												
4. _____																												
5. _____																												
6. _____																												
TOTAL =																												
	All 30 days in community living situations.	15-29 days in community living situations.	Less than 15 days in community living situations.																									

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Element 4: Cultural Competence	Yes	Sometimes/Somewhat	No	Missing
A. Does your family have frequent opportunities to tell the team about your beliefs and traditions?	2	1	0	666 777 888 999
B. Do all members of the team respect and abide by your family's beliefs and traditions?	2	1	0	666 777 888 999
C. Does the team help other people understand any ways that your child is different or unique from his or her peers?	2	1	0	666 777 888 999
D. Does anyone on the team act like she or he could be a better caregiver than you are for your child?	0	1	2	666 777 888 999

Element 5: Individual Services and Supports	Yes	Sometimes/Somewhat	No	Missing
A. Does the team understand your child and family well enough to effectively plan services and supports with you?	2	1	0	666 777 888 999
B. Did you take part in creating a written plan that identifies supports and services that meet your child's needs at home, at school, and in the community? <i>If yes or sometimes/somewhat, ask:</i> Do you have a copy of the written plan? YES NO <i>* Follow scoring rules.</i>	2	1	0	666 777 888 999
C. Do your child and family receive the supports and services stated in the plan?	2	1	0	666 777 888 999
D. Is there a crisis or safety plan that specifies what everyone must do?	2	1	0	666 777 888 999

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Element 6: Strengths-Based Services and Supports	Yes	Sometimes	No	666	777
A. Are the strengths and abilities of your child and family used in choosing supports and services?	2	1	0	666	777
B. Do people on the team help your child solve her or his own problems?	2	1	0	666	777
C. Does the team get your child involved with activities she or he likes and does well? Please give two examples of those activities: 1. <input style="width: 100%; height: 20px;" type="text"/> 2. <input style="width: 100%; height: 20px;" type="text"/>	2 Two examples of activities youth likes and does well.	1 One example of an activity youth likes and does well.	0 No examples of activities youth likes and does well.	666	777
<i>*Follow scoring rules.</i>					
D. Does the team spend too much time on the negative things that are happening with your child and family?	0	1	2	666	777

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Element 7: Natural Supports	Yes	Sometimes	No	666	777
A. Does the team help you receive support from your friends and family?	2	1	0	666	777
B. Does the team help your child develop friendships with other youth who will have a good influence on his or her behavior?	2	1	0	666	777
C. Does the team rely mostly on professional services?	0	1	2	666	777
D. How many members of your team are professionals? <input type="checkbox"/> More than half? <input type="checkbox"/> Half? <input type="checkbox"/> Less than half?	0 More than half.	1 Half.	2 Less than half.	666	777

Missing Data Codes: 666 Not Applicable; 777 Refused; 888 Don't Know; 999 Missing/Question Was Not Asked

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Element 8: Continuation of Services and Supports	Yes	Sometimes/Somewhat	No	Missing
A. Does the team help your family develop or strengthen relationships that will support you when the team is discontinued?	2	1	0	666 777 888 999
B. Do you think that in the future services will be there when you need them?	2	1	0	666 777 888 999
C. Does the team change the plan when your family's goals and needs change?	2	1	0	666 777 888 999
D. Is it possible for your child or family to get "kicked out" of services?	0	1	2	666 777 888 999

Element 9: Collaboration	Yes	Sometimes/Somewhat	No	Missing
A. Is it difficult to get different service providers (or agencies) to attend team meetings when they are needed?	0	1	2	666 777 888 999
B. Are all the possible sources of funding for your child's services explained to you in a way you can understand? <i>If answered "Somewhat" or "No," ask</i> Are the sources of funding explained to you at all?	2 Explained AND understood.	1 Explained but NOT understood.	0 Not explained.	666 777 888 999
C. Do the professionals and non-professionals on the team work together and hold one another responsible for specific tasks?	2	1	0	666 777 888 999
D. Do you feel there is unresolved tension or conflict on the team?	0	1	2	666 777 888 999

Element 10: Flexible Resources and Funding	Yes	Sometimes/Somewhat	No	Missing
A. Does the team use non-traditional services or even create new services for your child and family?	2	1	0	666 777 888 999
B. If your family needs a specific service or support would it be provided within an hour?	2	1	0	666 777 888 999
C. When the team has a good idea for a support or service for your child is money easily available to fund it?	2	1	0	666 777 888 999
D. Are the team meetings at a time or place that is not convenient for you?	0	1	2	666 777 888 999

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Element 11: Outcome-Based Services and Supports	CS	Some/Not at All	NO	Missing
A. Does the team measure your satisfaction and your child's satisfaction with services?	2	1	0	888 999 888 999
B. Does the team discuss your child's school attendance (or job/job training attendance if child is not enrolled in school) at every team meeting?	2	1	0	888 999 888 999
C. Does the team review your child's progress toward specific goals at every team meeting?	2	1	0	888 999 888 999
D. Does the team use data such as that described above to make decisions at team meetings?	2	1	0	888 999 888 999

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PROMOTING CULTURAL DIVERSITY AND CULTURAL COMPETENCY

Self-Assessment Checklist for Personnel Providing Services and Supports to Children with Disabilities & Special Health Needs and their Families

Directions: Please select A, B, or C for each item listed below.

A = Things I do frequently

B = Things I do occasionally

C = Things I do rarely or never

PHYSICAL ENVIRONMENT, MATERIALS & RESOURCES

- _____ 1. I display pictures, posters and other materials that reflect the cultures and ethnic backgrounds of children and families served by my program or agency.
- _____ 2. I insure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures of children and families served by my program or agency.
- _____ 3. When using videos, films or other media resources for health education, treatment or other interventions, I insure that they reflect the cultures of children and families served by my program or agency.
- _____ 4. When using food during an assessment, I insure that meals provided include foods that are unique to the cultural and ethnic backgrounds of children and families served by my program or agency.
- _____ 5. I insure that toys and other play accessories in reception areas and those, which are used during assessment, are representative of the various cultural and ethnic groups within the local community and the society in general.

COMMUNICATION STYLES

- _____ 6. For children who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment or other interventions.
- _____ 7. I attempt to determine any familial colloquialisms used by children and families that may impact on assessment, treatment or other interventions.
- _____ 8. I use visual aids, gestures, and physical prompts in my interactions with children who have limited English proficiency.
- _____ 9. I use bilingual staff or trained/certified interpreters for assessment, treatment and other interventions with children who have limited English Proficiency.
- _____ 10. I use bilingual staff or trained/certified interpreters during assessments, treatment sessions, meetings, and for or other events for families who would require this level of assistance.
- _____ 11. When interacting with parents who have limited English proficiency I always keep in mind that:
- _____ * limitations in English proficiency is in no way a reflection of their level of intellectual functioning.
 - _____ * their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.
 - _____ * they may or may not be literate in their language of origin or English.
- _____ 12. When possible, I insure that all notices and communiqués to parents are written in their language of origin.
- _____ 13. I understand that it may be necessary to use alternatives to written communications for some families, as word of mouth may be a preferred method of receiving information.
- _____ 14. I understand the principles and practices of linguistic competency and:
- _____ * apply them within my program or agency.
 - _____ * advocate for them within my program or agency.
- _____ 15. I understand the implications of health literacy within the context of my roles and responsibilities.
- _____ 16. I use alternative formats and varied approaches to communicate and share information with children and/or their family members who experience disability.

VALUES AND ATTITUDES

- _____ 17. I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.
- _____ 18. In group therapy or treatment situations, I discourage children from using racial and ethnic slurs by helping them understand that certain words can hurt others.
- _____ 19. I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with children and their parents served by my program or agency.
- _____ 20. I intervene in an appropriate manner when I observe other staff or parents within my program or agency engaging in behaviors that show cultural insensitivity, bias or prejudice.
- _____ 21. I understand and accept that family is defined differently by different cultures (e.g. extended family members, fictive kin, godparents).
- _____ 22. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.
- _____ 23. I accept and respect that male-female roles in families may vary significantly among different cultures (e.g. who makes major decisions for the family, play and social interactions expected of male and female children).
- _____ 24. I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g. high value placed on the decisions of elders or the role of the eldest male in families).
- _____ 25. Even though my professional or moral viewpoints may differ, I accept the family/parents as the ultimate decision makers for services and supports for their children.
- _____ 26. I recognize that the meaning or value of medical treatment, health care, and health education may vary greatly among cultures.
- _____ 27. I recognize and understand that beliefs and concepts of emotional well-being vary significantly from culture to culture.
- _____ 28. I understand that beliefs about mental illness and emotional disability are culturally-based. I accept that responses to these conditions and related treatment/interventions are heavily influenced by culture.
- _____ 29. I accept that religion and other beliefs may influence how families respond to illnesses, disease, disability and death.
- _____ 30. I recognize and accept that folk and religious beliefs may influence a family's reaction and approach to a child born with a disability or later diagnosed with a physical/emotional disability or special health care needs.

Tawara D. Goode - Georgetown University Center for Child & Human Development
University Center for Excellence in Developmental Disabilities Education, Research & Service

Adapted from - *Promoting Cultural Competence and Cultural Diversity in Early Intervention and Early Childhood Settings* - June 1989. Revised 1993, 1996, 1999, 2000, 2002, & 2004.

Page 3

- _____ 31. I understand that traditional approaches to disciplining children are influenced by culture.
- _____ 32. I understand that families from different cultures will have different expectations of their children for acquiring toileting, dressing, feeding, and other self-help skills.
- _____ 33. I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.
- _____ 34. Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs and expectations that are unique to families of specific cultures and ethnic groups served by my program or agency.
- _____ 35. I seek information from family members or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse children and families served by my program or agency.
- _____ 36. I advocate for the review of my program's or agency's mission statement, goals, policies, and procedures to insure that they incorporate principles and practices that promote cultural diversity and cultural competence.

How to use this checklist

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural diversity and cultural competence in human service settings. It provides concrete examples of the kinds of values and practices that foster such an environment. There is no answer key with correct responses. However, if you frequently responded "C", you may not necessarily demonstrate values and engage in practices that promote a culturally diverse and culturally competent service delivery system for children with disabilities or special health care needs and their families.



Checklist to Facilitate the Development of Linguistic Competence within Primary Health Care Organizations

Excerpt from Policy Brief 2- Linguistic Competence in Primary Health Care Delivery Systems: Implications for Policy Makers

Linguistic Competence: Policy Making Implications for Primary Health Care Organizations and Programs

Health care organizations have been slow to develop and implement policies and structures to guide the provision of interpretation and translation services. In the absence of policies, structures and fiscal resources, the burden of such services remain at the practitioner and consumer level. The following checklist is designed to assist primary health care organizations in developing policies, structures, practices and procedures that support linguistic competence.

Does the primary health care organization or program have:

- A mission statement that articulates its principles, rationale and values for providing linguistically and culturally competent health care services?
- Policies and procedures that support staff recruitment, hiring and retention to achieve the goal of a diverse and linguistically competent staff?
- Position description and personnel/performance measures that include skill sets related to linguistic competence?
- Policies and resources to support ongoing professional development and inservice training (at all levels) related to linguistic competence?
- Policies, procedures and fiscal planning to ensure the provision of translation and interpretation services?
- Policies and procedures regarding the translation of patient consent forms, educational materials and other information in formats that meet the literacy needs of patients?
- Policies and procedures to evaluate the quality and appropriateness of interpretation and translation services?
- Policies and procedures to periodically evaluate consumer and personnel satisfaction with interpretation and translation services that are provided?
- Policies and resources that support community outreach initiatives to persons with limited English proficiency?
- Policies and procedures to periodically review the current and emergent demographic trends for the geographic area served in order to determine interpretation and translation services needs?

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Checklist to Facilitate the Development of Policies, Structures and Partnerships that Support a Culturally Competent Research Agenda in Primary Health Care

Excerpt from Policy Brief 3- Cultural Competence in Primary Health Care: Partnerships for a Research Agenda

While many health care organizations have structures and policies that govern their participation in research, few mandate the incorporation of culturally competent and participatory action designs. This checklist is designed to assist primary health care organizations to develop policies, structures and practices that support partnerships to achieve a culturally competent research agenda.

If the primary health care organization/program conducts or participates in research, does it have:

- A policy that requires research initiatives to use culturally competent and participatory action methodologies that include the active involvement of consumers/key stakeholders in all aspects of research process (e.g. design, sampling, instrumentation, data collection and analysis, and dissemination)?
- Policy that delineates ethical considerations for conducting or participating in research initiatives?
- Organizational structures and resources to participate in and/or convene coalitions concerned with the broad range of health, social and environmental issues impacting racially, ethnically and culturally diverse populations?
- A policy and structures to meet with members of diverse communities and advocates to determine priority health issues and needs as a basis to develop collaborative research initiatives?
- A policy, structures and procedures to systemically collect, maintain and analyze health data specific to the racial, ethnic and cultural groups served?
- A policy and practices that support personnel to participate on review boards within universities, colleges and other organizations engaged in primary health care research?
- A policy, procedures and practices that support reciprocity within a given community that partners in research initiatives (e.g. economic benefits, employment and other resources)?
- A policy, structures and resources to pursue grants/contracts or collaborate with other organizations to conduct research initiatives concerned with eliminating health disparities?

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•E-mail: cultural@georgetown.edu• URL: <http://cucchi1.Georgetown.edu/hccc>•

- Personnel or employ consultants with expertise in conducting research that uses culturally competent and participatory action methodologies?
- Resources, policies and practices to provide information to consumers and communities about the benefits of participating or collaborating in research initiatives?
- Policies and structures to help bridge the gap between current research as it impacts racially, ethnically and culturally diverse groups and clinical practice including:
 - Personnel who periodically survey research studies and emerging bodies of evidence?
 - A mechanism to examine research findings and their implications for policy development, clinical protocols and health education?
 - Policy, structures and practices to conduct health education for consumers on research findings that them and the communities in which they live?

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Checklist to Facilitate Cultural Competence in Community Engagement

Excerpt from Policy Brief 4- Engaging Communities to Realize the Vision of *One Hundred Percent Access and Zero Health Disparities: A Culturally Competent Approach*

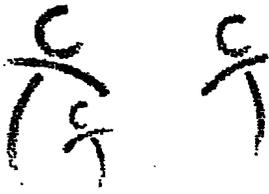
Community Engagement: Policy Implications for Primary Health Care Organizations

Health care organizations should give careful consideration to the values and principles that govern their participation in community engagement. This checklist is designed to guide them in developing and administering policy that supports cultural and linguistic competence in community engagement.

Does the health care organization have:

- A mission that values communities as essential allies in achieving its overall goals?
- A policy and structures that delineate community and consumer participation in planning, implementing and evaluating the delivery of services and supports?
- A policy that facilitates employment and the exchange of goods and services from local communities?
- A policy and structures that provide a mechanism for the provision of fiscal resources and in-kind contributions to community partners, agencies or organizations?
- Position descriptions and personnel performance measures that include areas of knowledge and skill sets related to community engagement?
- A policy, structures and resources for in-service training, continuing education and professional development that increase capacity for collaboration and partnerships within culturally and linguistically diverse communities?
- A policy that supports the use of diverse communication modalities and technologies for sharing information with communities?
- A policy and structures to periodically review current and emergent demographic trends to:
 - Determine whether community partners are representative of the diverse population in the geographic or service area?
 - Identify new collaborators and potential opportunities for community engagement?
- A policy, structures and resources to support community engagement in languages other than English?

•National Center for Cultural Competence• 3307 M Street, NW, Suite 401, Washington, DC 20007-3935•
•Voice: 800.788.2066 or 202.687.5387• TTY: 202.687.5503• Fax: 202.687.8899•
•E-mail: cultural@georgetown.edu• URL: <http://cucchi1.Georgetown.edu/nccc>•



Checklist to Facilitate the Development of Culturally and Linguistically Competent Primary Health Care Policies and Structures

Excerpt from Policy Brief 1- Rationale for Cultural Competence in Primary Health Care

The following checklist is targeted to individuals who have a role in the shaping of policy at the Federal, state, local and program levels. Policy makers may be board members of private agencies, public agency officials, legislators, commissioners, advisory committee members, agency directors and staff of consumer/family organizations. The goal of this checklist is to facilitate policy making that supports culturally and linguistically competent primary health care services.

Does the primary care system, organization or program have:

- A mission statement that articulates its principles, rationale and values for culturally and linguistically competent health and mental health care service delivery?
- Policies and procedures that support a practice model which incorporates culture in the delivery of services to culturally and linguistically diverse groups?
- Structures to assure the meaningful participation of consumers and communities in planning, delivery and evaluation of services?
- Processes to review policy and procedures systematically to assess their relevance for the delivery of culturally competent services?
- Policies and procedures for staff recruitment, hiring and retention that will achieve the goal of a diverse and culturally competent workforce?
- Policies and resources to support ongoing professional development and in-service training (at all levels) for awareness, knowledge and skills in the area of cultural and linguistic competence?
- Policies to assure that new staff are provided with training, technical assistance and other supports necessary to work within culturally and linguistically diverse communities?
- Position descriptions and personnel/performance measures that include skill sets related to cultural and linguistic competence?
- Fiscal support and incentives for the improvement of cultural competence at the board, agency, program and staff levels?
- Policies for and procedures to review periodically the current and emergent demographic trends for the geographic area it serves?

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- Methods to identify and acquire knowledge about health beliefs and practices of emergent or new populations in service delivery areas?
- Policies and allocated resources for the provision of translation and interpretation services, and communication in alternative formats?
- Policies and resources that support community outreach initiatives for those with limited English proficiency and/or populations that are not literate or have low literacy skills?
- Requirements that contracting procedures and proposals and/or request for services include culturally and linguistically competent practices?

• National Center for Cultural Competence • 3307 M Street, NW, Suite 401, Washington, DC 20007-3935 •
• Voice: 800.788.2066 or 202.687.5387 • TTY: 202.687.5503 • Fax: 202.687.8899 •
• E-mail: cultural@georgetown.edu • URL: <http://cucchi1.Georgetown.edu/hccc> •



SUSTAINABILITY SELF-ASSESSMENT TOOL (Updated 12/23/03)

**Examples of Key Indicators for Some of the Attributes of the System of Care Framework

Service Array

- Service staff is available during times convenient and acceptable to families.
- Services are provided at locations convenient to families and at locations of the families choosing (e.g., homes, schools or other community-based settings).
- The array accounts for and is respectful of families' cultures.
- Transportation is provided.
- Childcare is provided.
- Families are aware of the referral process and can self-refer into the service delivery system.
- Flexible funds are in place to meet unique needs.
- Service plans are individualized according to the child and family strengths and needs.
- Crisis and transition plans are provided as part of the treatment planning process.
- Staff, families, and youth have been trained on the process for linking strengths with needs to develop service plans and coordinate care.

Management and Coordination

- Current leaders are supported and report reduced stress.
- New leaders are identified that reflect the diversity of the community served.
- Training and support of all leaders involved in the effort is being conducted resulting in decreased staff turnover and increased job satisfaction.
- Clinical and fiscal utilization, management and quality improvement processes are in place.
- A social marketing plan is completed detailing how data will be used to arm advocates with information required to impact state and local policy.



SUSTAINABILITY SELF-ASSESSMENT TOOL (Updated 12/23/03)

Interagency Planning and Coordination

- Interagency structure is in place and meetings are conducted for system level policy, planning and coordination purposes.
- Training curricula and materials are developed jointly by cooperating agencies and organizations.
- Joint training is conducted with staff of cooperating agencies and organizations.
- Staff are shared and/or coordinated between cooperating agencies and organizations.
- Staff are out-stationed or co-located at cooperating agencies and organizations.
- Procedures for pooling, blending, or braiding of funds across agencies are established.
- Universal process for cross-system communication is in place.
- Interagency service and treatment planning meetings are conducted regularly.
- Interagency case/care management and case/care review meetings are conducted regularly.
- Joint staff meetings are conducted.
- Joint hiring/recruitment of staff is conducted that reflect the diversity of the population served.
- Interagency cooperation is in place for shared administrative forms, unified case records, integrated MIS systems, and joint administrative/system implementation meetings.

Family and Youth Involvement

- Families and youth are hired as part of the administrative team.
- Families and youth are provided with information enabling them to actively advocate for policy, system and practice change.
- Families and youth are involved in reforming existing policies.
- Families and youth are represented on governing and policy bodies and committees.
- Family members and youth receive stipends to attend meetings including childcare, transportation and other assistance.
- Family members and youth are involved in developing and providing training to service providers.



SUSTAINABILITY SELF-ASSESSMENT TOOL (Updated 12/23/03)

Implementing Strategic Financing Strategies

- Redeployment of funds is assessed and implemented.
- Programs are operated more efficiently by cutting costs and reinvesting funds.
- Reinvestment is accomplished by allocating funds that can be "saved" through redeployment, refinancing, or reductions in spending, or using in-kind resources.
- Diversification of funding is accomplished.
- Federal revenue is leveraged by taking advantage of programs that provide funding contingent on state, local or private financing; refinancing.
- Administrative claiming is in place.
- Grants are written and submitted on a regular basis.
- Funds are pooled, blended, or braided to create unified funding streams.
- Categorical funding across agencies is coordinated and aligned to support community services.
- Medicaid and/or Title IV-E Waivers are being sought and/or implemented.
- Devolution or de-categorization of funding streams is completed to remove narrow eligibility requirements and rules and to expand array of supports and services currently unavailable to families.
- Partnerships are in place to expand the fiscal base and leverages funds.
- New, shared public-private leadership at state and local levels is established that fosters investments in children and families.
- Technical assistance is provided to public and private agencies to share knowledge and skills needed to create and sustain system of care services and supports.

Followup Study Attrition Projection

1. Data Collection Schedule

year	yr1	yr2	yr3	yr4	yr5	yr6	yr7	yr8	yr9	yr10	yr11	yr12
months	1-3	4-6	7-9	10-12	1-3	4-6	7-9	10-12	1-3	4-6	7-9	10-12

cohort 1	baseline	wave 1	wave 2	wave 3	wave 4	wave 5
	150	90	72	58	46	37

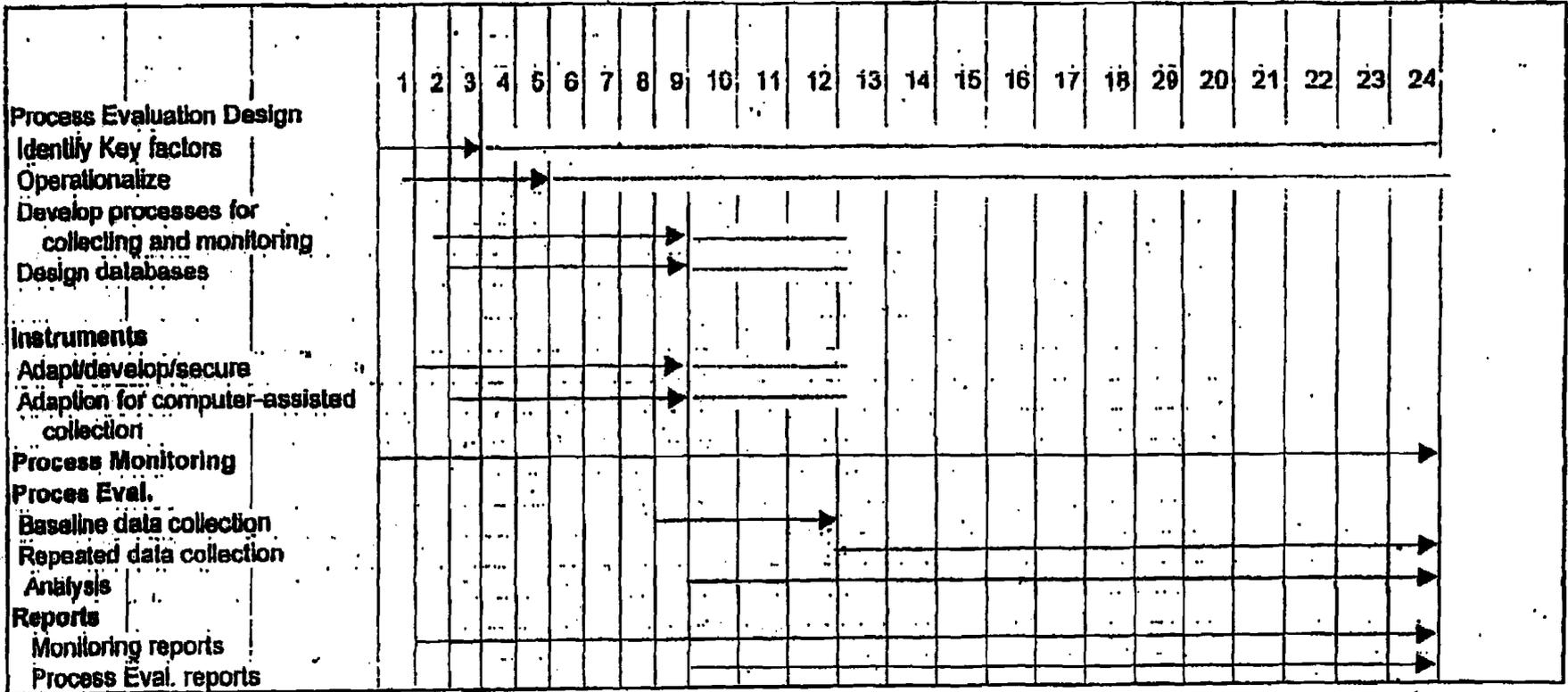
cohort 2	baseline	wave 1	wave 2	wave 3	wave 4
	150	90	72	58	46

cohort 3	baseline	wave 1	wave 2	wave 3	wave 4
	150	90	72	58	46

2. Summary of Subjects by Data Collection Wave

Recruitment Sources	Wave 1		Wave 2		Wave 3		Wave 4		Wave 5	
	data	followup	data	followup	data	followup	data	followup	data	followup
Cohort 1	150	90	72	58	46	37				
Cohort 2	150	90	72	58	40	37				
Cohort 3	150	90	72	58	46					
Total N	450	270	216	173	138	74				
Cumulative number of observations	450	720	938	1,109	1,247	1,321				

011



Appendix 4:
Sample Consent Forms

CONSENT TO PARTICIPATE IN SERVICES

TITLE OF PROJECT: Alliance System of Care for Children and Families

PARENT/GUARDIAN: _____

You and your child are being invited to take part in a project called the Alliance System of Care for Children and Families conducted by the Harris County Alliance for Children and Adults. The point of entry into the Alliance SOC is the **Alliance Resource Coordination Team (ARCT)** which is the service-level coordination and service delivery structure of our local system of care. The ARCT Coordinator has determined that you and your child are eligible for the project because your child meets diagnostic criteria for Serious Emotional Disorder (SED) and has a history of multi-agency use.

This project involves three components in which you can decide to participate. They include participation in development of an individual service plan and its chosen services, program evaluation/data collection, and a national data sharing activity. Your decision to participate in any of them is voluntary and you may choose to withdraw from them at any time. If you decide not to participate in any of the components of this project, other services available to you from the Alliance and its member agencies will not be affected.

PURPOSE OF PROJECT:

The Alliance System of Care for Children and Families is a project designed to provide integrated mental health and support services for children and youth with SED and their families. The goals of participation are that youth with SED (1) can live at home, 2) attend school every day, and 3) complete their developmental milestones.

The Alliance is comprised of a variety of child-serving community based agencies that deliver services and supports in mental health, child welfare, juvenile justice, education, primary health care, substance abuse treatment and prevention services, and vocational services/rehabilitation. Parent representatives are an integral part of the Alliance. Services are designed to be family centered and culturally competent.

PROCEDURES

If you agree to participate in the primary project component that involves developing your child's and family's Individual Service Plan and use of services you may be involved for up to 3 years. The following steps describe what to expect as a participant in the service component of the project:

1. The ARCT Coordinator will request that a designated care coordinator or parent partner contact the family to complete a strengths-based assessment and signed permissions to request additional information. A Care Management Team unique for each family will be organized and will include a facilitator specifically trained in Family Conferencing and System of Care, professional and non-professional helpers, caregivers and others important in the child's life.
2. The individualized care team, guided by the status of youth needs and family strengths as determined by the assessment and other information, will develop an individualized service and safety plan with recommendations for a range of services and supports, including Wraparound (intensive case management).
3. **Parents then choose the services and supports** that you feel are best for your child and family from the proposed plans. If you choose to participate in Wraparound, you will receive assistance from a

Harris County Alliance Care Coordinator and/or Parent Partner to identify and coordinate service delivery with the multiple service providers and supports for you, your child & other family members. If you do not choose to participate in Wraparound Case Management, you and your child may continue to use the case management provided by your referring agency. You can still access services described in your service plan.

4. Parents and child will attend ongoing Care Management Team meetings with formal and informal supports as guided by the service plan. Changes to the plan can be made as needed.
5. You will not have to pay any additional cost beyond the traditional sources (such as Medicaid, private insurance) for services listed in your family's plan. The project is supported through federal, state, and county funds to cover these additional costs for services and supports.
6. You and your family will be offered ongoing training in service plan development and the wraparound process, as well as opportunities to participate in overall system planning and program evaluation.

Risks/Discomforts

There are no physical risks involved in this project. Some of the questions or issues discussed in the team meetings are sensitive and may be uncomfortable. We will have experienced clinicians available to help you or your child with any issues that may arise.

Benefits

During the project, you and your child will receive services that should meet your needs and help you in many ways. In particular, as a result of these services it is expected that your child will be able to experience improved developmental outcomes and sense of well being. Furthermore, you will help us demonstrate increased effectiveness in serving children with SED and their families using an integrated system of care.

Confidentiality

We will keep all service plans and assessment results in your personal client record, which is strictly confidential to the fullest extent permitted by law. Only staff associated with your Care Management Team and the Alliance Evaluation Team will have access to your assessment results, plans and your use of services for overall monitoring of the system of care delivery. Transfer of your personal information between service providers to help with your access to services will only be done upon your signed Release of Information. HIPAA guidelines will direct the confidentiality of your information as well as the privacy practices of the agencies involved.

Your and your child's identity and the information you share in your Team meetings will also be protected through a federal Certificate of Confidentiality from the National Institute on Drug Abuse. This document states that project staff cannot be forced to release your name or any information you tell us about substance use related activities to any court or legal proceeding, even under a court order or subpoena. This protection does not cover circumstances we are required to report by law such as possible child abuse or your or your child's stated intention to harm yourselves or someone else so you can get help.

RIGHT TO WITHDRAW:

Participation on the Care Management Team and in services is voluntary, and you and your child may stop involvement at anytime. You may also refuse to answer any questions asked or written on any forms. However, the questions asked are designed to collect information that will help us know what your needs are and contribute to your plan of services.

If you decide not to participate in this project component, your access to other services from the Alliance for Children and Adults for your child and family will not be affected. If you have any questions about this project and your participation you can contact Jeannette Truxillo, DrPH, The Alliance Evaluation Coordinator, at 713-802-7752.

SIGNATURES

Sign below only if you understand the information given to you about this project and choose to participate. Be sure that your questions have been answered and that you understand the study. If you have any questions about your rights as a research subject to report a research-related injury call Isabel Rios, Human Subjects Administrator at 713-802-3877

Child Name (1)

Name of Parent/Guardian

Signature of Parent/Guardian

Date

Address

Phone number

Name of person obtaining consent

Signature of person obtaining consent

Date

This study (#) and Informed Consent form were approved by the Committee for the Protection of Human Subjects of DePelchin Children's Center on

Appendix 5:
Non-Federal Match Certification



TEXAS DEPARTMENT OF STATE HEALTH SERVICES

EDUARDO J. SANCHEZ, M.D., M.P.H.
COMMISSIONER

1100 W. 49th Street • Austin, Texas 78756
1-888-963-7111 • <http://www.dshs.state.tx.us>

May 9, 2005

Diane L. Sondheim
Deputy Chief
Child, Adolescent and Family Branch
Division of Service and System Improvement
1 Choke Cherry Road, Room 6-1043
Rockville, Maryland 20857

RE: Governor's Letter of Assurance for Harris County, Texas application for
SAMHSA Child Mental Health Initiative (SM-05-010) for FY 2005-06

Ms. Sondheim:

This is to verify that the Texas Department of State Health Services has been designated by the office of Texas Governor Rick Perry to be the agency with all assurance and signatory authority pertaining to the SAMHSA Cooperative Agreement for Comprehensive Community Mental Health Services for Children and their Families program.

It is understood that Harris County, Texas, is an applicant for SAMHSA Child Mental Health Initiative funds for fiscal year 2005-06, and will continue to seek funding through FY 2011 (a 6 year cooperative agreement). The lead agency and fiscal agent is Harris County Protective Services for Children and Adults (HCPS). The HCPS TRIAD Prevention Program will administer the *Harris County Alliance for Children and Families*. The Alliance is a multi-agency and family collaborative serving the function of the state-mandated Community Resource Coordination Group (CRCG) in order to coordinate and facilitate services and supports to children with special needs involved with multiple youth service agencies. The Alliance will provide local leadership in developing a system of care whose goal is to transform the delivery of mental health services to Texas children and youth with severe emotional disturbances (SED) and their families.

Services required in this cooperative agreement are covered in the State Medicaid Plan. The State of Texas have entered into participatory agreements under the State plan with Harris County Juvenile Probation Department, Mental Health Mental Retardation Authority of Harris County, and Harris County Protective Services to provide direct services required in the SAMHSA cooperative agreement. These agencies are qualified to receive payments under the State Medicaid Plan. All other designated and participating service providers will be required to enter into a participation agreement under the State Medicaid Plan and will be qualified to receive Texas Medicaid payments.

Diane L. Sondheim

May 9, 2005

Page 2

The vision and goals of *Harris County Alliance for Children and Families* system of care proposed under this Request for Applications are specifically included in the goals of the Texas Community Mental Health Services Block Grant Plan, as authorized in Section 564 (b) of the HCS Act, and in the Texas Mental Health Plan for Children and Adolescents with Serious Emotional Disturbances, submitted under Public Law (PL) 102-321. The Alliance system of care is consistent with plans proposed under all SAMHSA-funded State Incentive Grant and/or State Infrastructure grants awarded to Texas.

The Texas Department of State Health Services supports the development and expansion of the Harris County Alliance for Children and Families system of care, and is committed to assist in cultivating the community and interagency partnerships necessary to build and sustain this system of care.

Sincerely,

Dave Wanser Ph.D.

Dave Wanser, Ph.D.

Deputy Commissioner, Behavioral and Community Health Services

Department of State Health Services

**MEMORANDUM OF UNDERSTANDING
FOR THE COORDINATION OF MENTAL HEALTH SERVICES
BETWEEN THE TRIAD AGENCIES
FOR
THE HARRIS COUNTY ALLIANCE FOR CHILDREN AND FAMILIES: MENTAL
HEALTH PROJECT**

PURPOSE

In 1974, the Harris County Children's Protective Services (now known as Harris County Protective Services for Children and Adults, CPS), the Harris County Juvenile Probation Department (HCJPD) and the Mental Health and Mental Retardation Authority of Harris County (MHMRA) approached the Harris County Commissioners' Court for funding to develop programs and residential services for at-risk youth in Harris County. Funding was granted and the alliance between the agencies has become known as "TRIAD". Although TRIAD is not a legal entity in itself, it is a consortium of three county agencies working with the community to coordinate services by the most efficient means to provide comprehensive intervention, prevention and support services to the youth and families.

PLEDGE

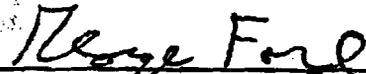
In furtherance of the efforts by the Harris County Alliance for Children and Families (Harris County Alliance) to improve the system of care for youth living with serious emotional disturbances (SED) through a public/private multi-agency interdisciplinary approach, the TRIAD agencies of Harris County have agreed to the following:

1. Agree to deliver and/or coordinate the required mental health services and supports with public and private providers who administer those services in accordance with Federal entitlements that may include: Medicaid, State Children's Health Improvement Program (S-CHIP), Title IV-B (Child Welfare/Family Preservation and Support Services), Title IV-E (Foster Care, Adoption and Independent Living), and Individuals with Disabilities Education Act (IDEA).
2. Utilize, coordinate and partner with public and private agencies that have received other Federal discretionary grant funds that may include: the Minority Substance Abuse Prevention and HIV Prevention Services Program Grant (CSAP), the National Child Traumatic Stress Initiative Grant (CMHS), and the Youth Violence Prevention (CMHS) from the Substance Abuse and Mental Health Services Administration (SAMHSA).
3. Authorize CPS to serve as the administering agency of TRIAD and authorize the CPS Executive Director to serve as the Principal Investigator for the Harris County Alliance for Children and Families: Mental Health Project.
4. Agree to serve on the Governing Board with other child-serving agencies, youth and parents to make effective changes in the system of care.
5. Create a child-centered and family-focused strategic plan for youth that embraces community-based culturally competent services and supports.

6. **Implement and enforce**, Memorandums of Understanding with other child-serving agencies and organizations and work to eliminate barriers in service integration through procedure and policy changes.
7. **Develop** mechanisms for managing, coordinating, and evaluating program strategies and services.
6. **Hire** Project Director to oversee the implementation of the system of care strategic plan and work with key staff to make effective changes at the local and state level.
7. **Improve and strengthen** relationships with other child-serving agencies in Harris County.
8. **Subscribe** to interdisciplinary training initiatives and values for all participants in the **Harris County Alliance**.
9. **Provide** support staff along with other partners in furtherance of these efforts.

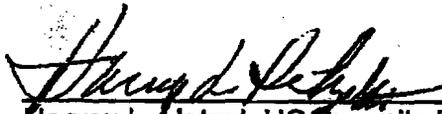
AFFIRMATION

We, the Executive Directors of the TRAIID agencies have signed below to verify our commitment to making effective changes in the system of care for youth with SED to provide comprehensive seamless mental health and social services.



 George Ford, HC Protective Services

Date 5/13/05



 Harvey L. Hetzel, HC Juvenile Probation Dept.

Date 5/13/05



 Steve Schnee, Ph.D, Executive Director
 Harris County Mental Health Mental Retardation
 Authority

Date 5/13/05

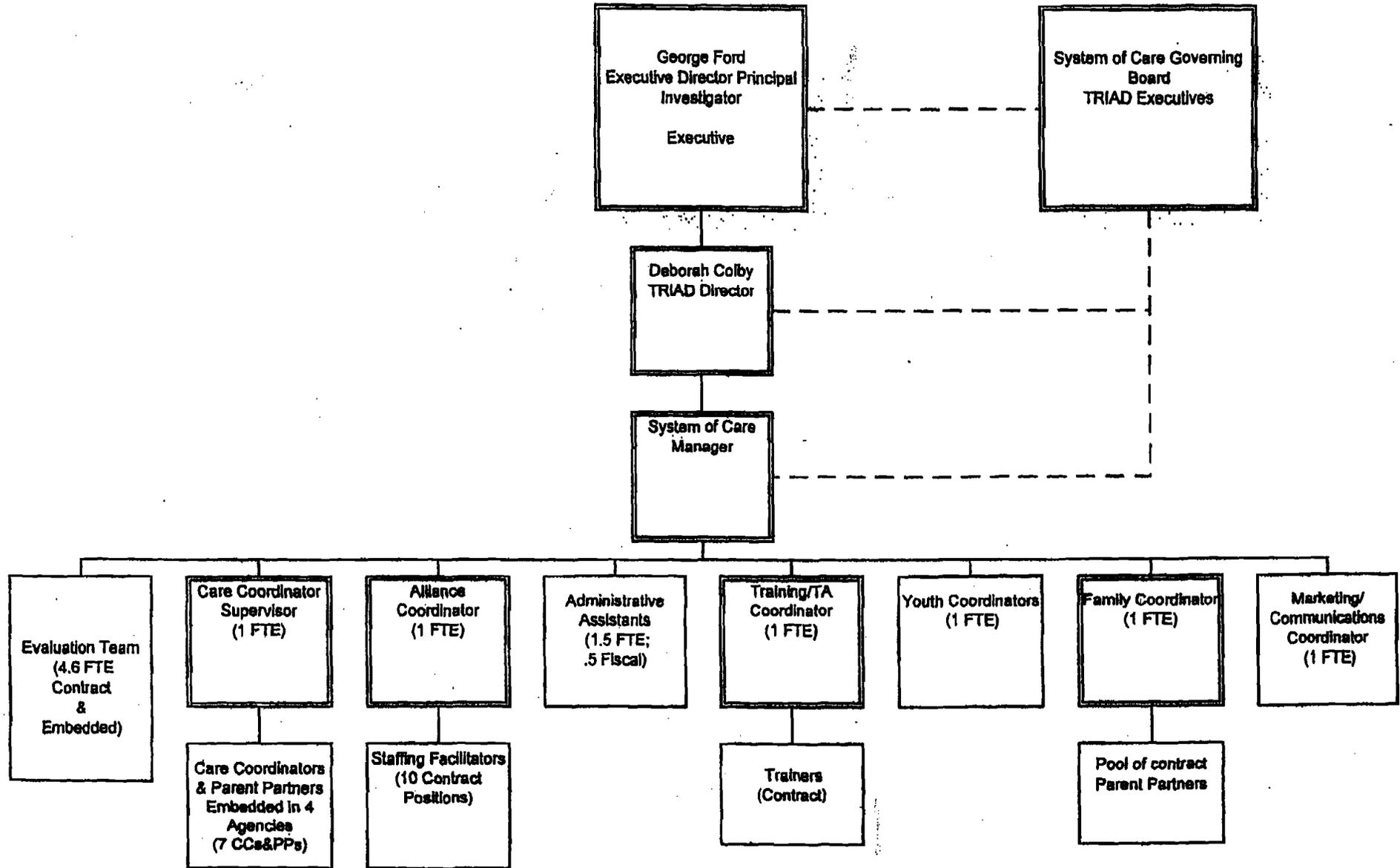


Appendix 6:
Organizational Chart, Staffing Pattern, Timetable
And
Management Chart

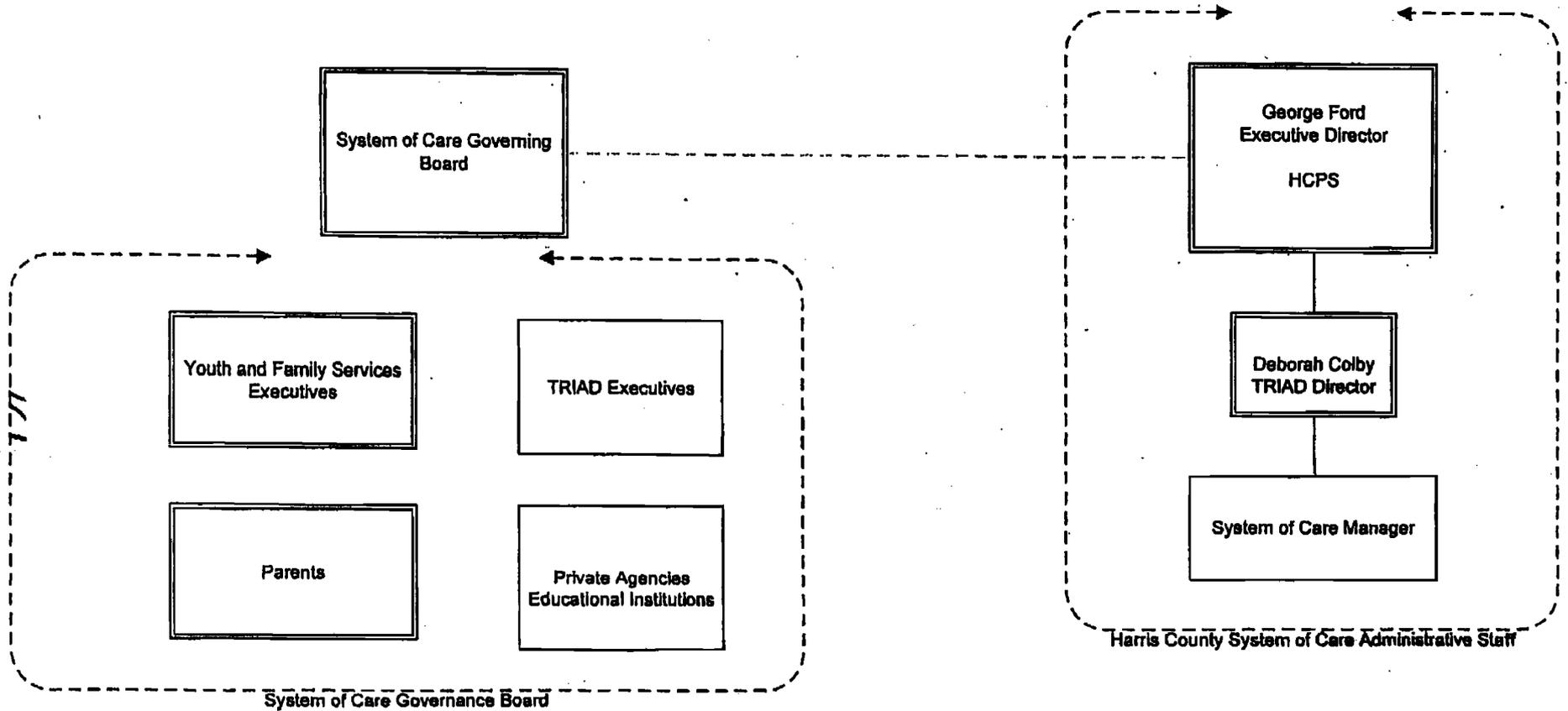
Harris County Alliance for Children & Families System of Care

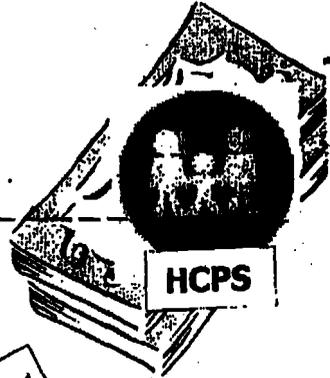
TRIAD

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Harris County System of Care Governance Team





Governance



System of Care Governance Board

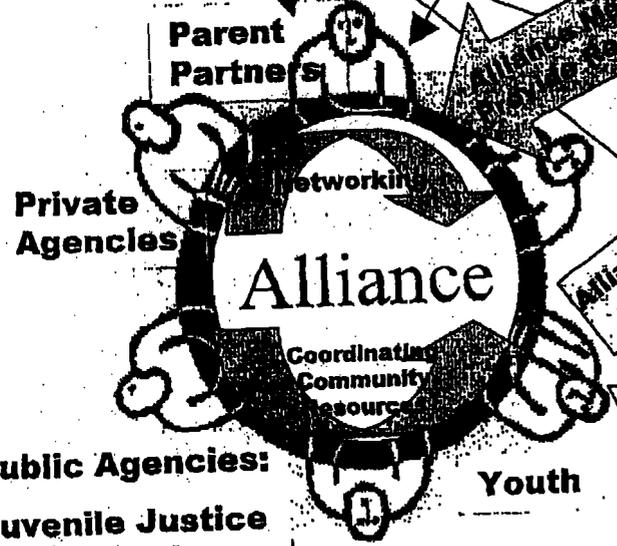
System of Care Program Manager



System of Care TRAINING



Fiscal Agent



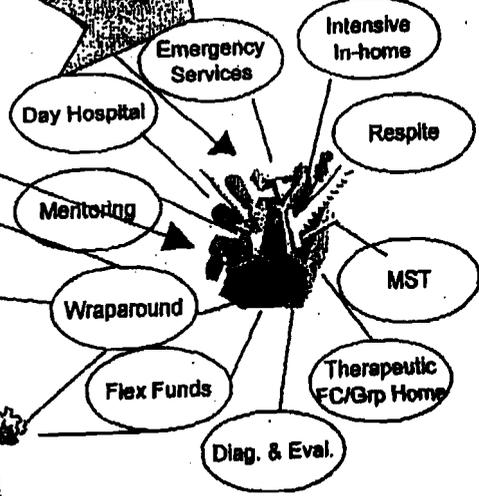
Private Agencies

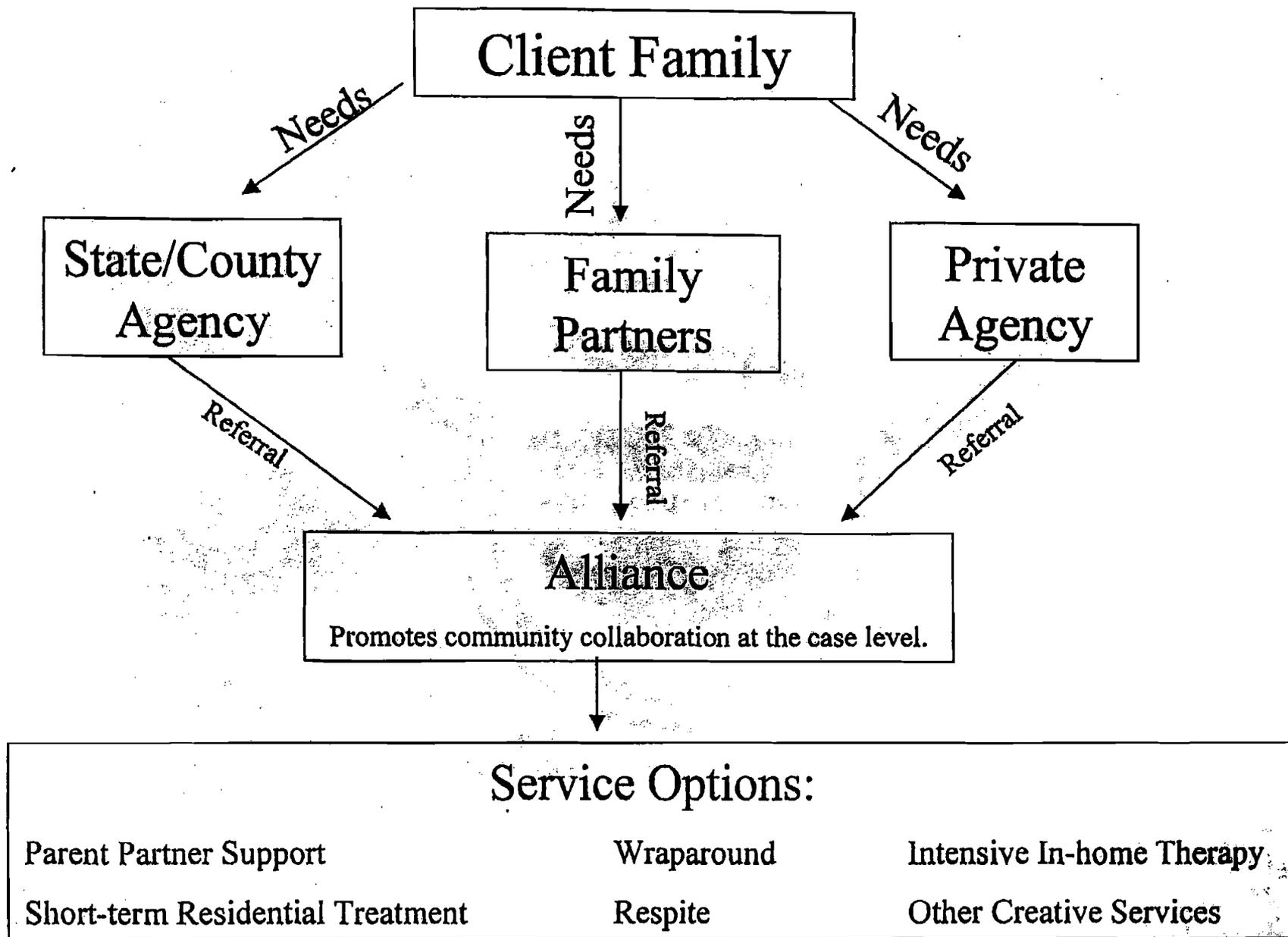
Public Agencies:
Juvenile Justice
CPS Schools
Mental Health

Youth



Embedded Wraparound Coordinators





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HARRIS COUNTY ALLIANCE FOR CHILDREN AND FAMILIES: MENTAL HEALTH PROJECT

6-YEAR SUMMARY OF MAIN TASKS

Funding Year	Main Tasks
One	<ol style="list-style-type: none"> 1. Organize Governing Body: Meet with partners that organized and completed the cooperative working agreement; choose family members to serve on Governing Board; hire Project Director elect governing body chair and establish policies and procedure; and adopt a logic model for the comprehensive system of care. 2. Organize the Administrative Team; maintain direct contact with governing body; employ key staff; organize administrative team; and assist in the development of strategic plan. 3. Complete an inclusive theory-based strategic that will result in a comprehensive, seamless, and family-focused system of care for youth with SED. 4. Assess existing management information systems, identify management information systems, purchase software and related equipment and train appropriate staff. 5. Strengthen partnerships with child-serving agencies, family members, community leaders, and other local stakeholders. 6. Create training strategies and identify research-based training curricula to be used by the Alliance and train partners and Governing Board. 7. Identify contract vendor to assess and create social marketing strategic plan to generate publicity and public awareness. Kick-off media campaign for service implementation in Year 2.
Two	<ol style="list-style-type: none"> 1. Commence implementation of system of care. Accept referrals and identify youth and families to receive services. 2. Continue to implement social marketing plan and community outreach efforts by targeting undeserved populations. 3. Provide orientations to youth and families concerning the local and national program evaluations. 4. Implement the interdisciplinary training component to provide training to future practitioners, parent organizations, and community organizations. 5. State and Local Liaison commences duties to advocate and inform legislators concerning systems of care.
Three	<ol style="list-style-type: none"> 1. Re-evaluate logic model strategic plan based on evaluation data that will include consumer surveys other data maintained by the Lead Evaluator, and input from the various partners. Amend strategic plan on the assessment in order to improve service delivery. 2. Continue to refer and enroll youth and families for service. 3. Re-assess social marketing plan and continue to improve marketing efforts. 4. Re-evaluate training component and continue training initiatives. 5. Develop financial strategic plan to continue services after the expiration of the cooperative working agreement. 6. Continue advocacy via the efforts of the State and Local Liaisons.
Four	<ol style="list-style-type: none"> 1. Continue to serve youth and families by improving and expanding services in the system of care. 2. Implement sustainability strategic plan in order to continue the progress made under the SAMHSA Cooperative Agreement, which will include submitting applications for funding to private foundations. 3. Continue advocacy via the efforts of the State and Local Liaisons.
Five	<ol style="list-style-type: none"> 1. Continue to serve youth and families by improving and expanding services in the system of care. 2. Re-evaluate logic model strategic plan based on evaluation data and amend strategic plan accordingly. 3. Re-assess social marketing plan and continue to improve media campaign and community outreach efforts 4. Re-evaluate training component and continue training initiatives.
Six	<ol style="list-style-type: none"> 1. Continue to serve youth and families by improving and expanding services in the system of care. 2. Continue social marketing, training, sustainability and advocacy strategic plans.

Assurances

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions; searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

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

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

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

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended; (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL X 	TITLE Harris County Judge
APPLICANT ORGANIZATION Harris County Protective Services for Children and Adults	DATE SUBMITTED 05/13/2005

Certifications

1000-100-1000

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

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

- (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

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

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

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

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about--
 - (1) The dangers of drug abuse in the workplace;
 - (2) The grantee's policy of maintaining a drug-free workplace;
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 - (1) Abide by the terms of the statement; and
 - (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

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

- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--
- (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

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

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

3. CERTIFICATION REGARDING LOBBYING

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

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

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under-

signed, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

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

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

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

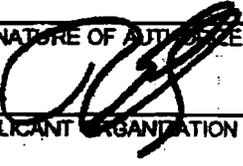
Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services,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

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

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

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

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

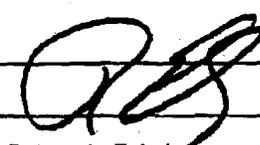
SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL 	TITLE Harris County Judge	
APPLICANT ORGANIZATION Harris County Protective Services for Children and Adults		DATE SUBMITTED 05/13/2005

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DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

<p>1. Type of Federal Action:</p> <p><input checked="" type="checkbox"/> a. contract <input type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance</p>	<p>2. Status of Federal Action</p> <p><input checked="" type="checkbox"/> a. bid/offer/application <input type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award</p>	<p>3. Report Type:</p> <p><input checked="" type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change</p> <p>For Material Change Only: Year _____ Quarter _____ date of last report _____</p>
<p>4. Name and Address of Reporting Entity:</p> <p><input checked="" type="checkbox"/> Prime <input type="checkbox"/> Subawardee</p> <p align="center">Tier _____, if known:</p> <p>Harris County Protective Services 2525 Murworth Houston, TX 77054</p> <p>Congressional District, if known:</p>	<p>5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:</p> <p align="center">Congressional District, if known:</p>	
<p>6. Federal Department/Agency:</p> <p>Department of Health and Human Services</p>	<p>7. Federal Program Name/Description:</p> <p>Substance Abuse & Mental Health Services Administration Center for Mental Health Services (CMHS)</p> <p>CFDA Number, if applicable: 93.104</p>	
<p>8. Federal Action Number, if known:</p>	<p>9. Award Amount, if known:</p> <p>\$ _____</p>	
<p>10. a. Name and Address of Lobbying Entity (if individual, last name, first name, MI):</p>	<p>b. Individuals Performing Services (including address if different from No. 10a.) (last name, first name, MI):</p>	
<p>11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.</p>	<p>Signature: </p> <p>Print Name: <u>Robert A. Eckels</u></p> <p>Title: <u>Harris County Judge</u></p> <p>Telephone No.: <u>(713) 755-4000</u> Date: <u>05/13/2005</u></p>	
<p>Federal Use Only</p>		<p>Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)</p>

CHECKLIST

Public Burden Statement: Public reporting burden of this collection of information is estimated to average 4 - 50 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC.

Clearance Officer, 1800 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0620-0428). Do not send the completed form to this address.

NOTE TO APPLICANT: This form must be completed and submitted with the original of your application. Be sure to complete both sides of this form. Check the appropriate boxes and provide the information requested. This form should be attached as the last page of the signed original of the application. This page is reserved for PHS staff use only.

Type of Application: NEW Noncompeting Continuation Competing Continuation Supplemental

PART A: The following checklist is provided to assure that proper signatures, assurances, and certifications have been submitted.

- | | Included | NOT Applicable |
|--|-------------------------------------|--------------------------|
| 1. Proper Signature and Date for Item 18 on SF 424 (FACE PAGE) | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. Proper Signature and Date on PHS-5161-1 "Certifications" page. | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 3. Proper Signature and Date on appropriate "Assurances" page, i.e., SF-424B (Non-Construction Programs) or SF-424D (Construction Programs) | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 4. If your organization currently has on file with DHHS the following assurances, please identify which have been filed by indicating the date of such filing on the line provided. (All four have been consolidated into a single form, HHS Form 690) | | |
| <input checked="" type="checkbox"/> Civil Rights Assurance (45 CFR 80) | _____ | _____ |
| <input checked="" type="checkbox"/> Assurance Concerning the Handicapped (45 CFR 84) | _____ | _____ |
| <input checked="" type="checkbox"/> Assurance Concerning Sex Discrimination (45 CFR 86) | _____ | _____ |
| <input checked="" type="checkbox"/> Assurance Concerning Age Discrimination (45 CFR 90 & 45 CFR 91) | _____ | _____ |
| 5. Human Subjects Certification, when applicable (45 CFR 46) | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

PART B: This part is provided to assure that pertinent information has been addressed and included in the application.

- | | YES | NOT Applicable |
|---|-------------------------------------|-------------------------------------|
| 1. Has a Public Health System Impact Statement for the proposed program/project been completed and distributed as required? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Has the appropriate box been checked for item # 16 on the SF-424 (FACE PAGE) regarding intergovernmental review under E.O. 12372 ? (45 CFR Part 100) | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 3. Has the entire proposed project period been identified in item # 13 of the FACE PAGE? | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 4. Have biographical sketch(es) with job description(s) been attached, when required? | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 5. Has the "Budget Information" page, SF-424A (Non-Construction Programs) or SF-424C (Construction Programs), been completed and included? | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 6. Has the 12 month detailed budget been provided? | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 7. Has the budget for the entire proposed project period with sufficient detail been provided? | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 8. For a Supplemental application, does the detailed budget address only the additional funds requested? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. For Competing Continuation and Supplemental applications, has a progress report been included? | <input type="checkbox"/> | <input type="checkbox"/> |

PART C: In the spaces provided below, please provide the requested information.

Business Official to be notified if an award is to be made.

Program Director/Project Director/Principal Investigator designated to direct the proposed project or program.

Name Beverly Pettway
 Title Chief Financial Officer
 Organization Harris County Protective Services
 Address 2525 Murworth, Houston TX 77054
 E-mail Address beverly_pettway@co.harris.tx.us
 Telephone Number (713) 394-4071
 Fax Number _____

Name George Ford
 Title Executive Director
 Organization Harris County Protective Services
 Address 2525 Murworth, Houston, TX 77054
 E-mail Address george_ford@co.harris.tx.us
 Telephone Number (713) 394-4070
 Fax Number (713) 394-4051

APPLICANT ORGANIZATION'S 12-DIGIT DHHS EIN (if already assigned)

7 6 - 0 4 5 4 5 1 4

SOCIAL SECURITY NUMBER

_____-____-____

HIGHEST DEGREE EARNED

J. D.

(OVER)

PART D: A private, nonprofit organization must include evidence of its nonprofit status with the application. Any of the following is acceptable evidence. Check the appropriate box or complete the "Previously Filed" section, whichever is applicable.

- (a) A reference to the organization's listing in the Internal Revenue Service's (IRS) most recent list of tax-exempt organizations described in section 501(c)(3) of the IRS Code.
- (b) A copy of a currently valid Internal Revenue Service Tax exemption certificate.
- (c) A statement from a State taxing body, State Attorney General, or other appropriate State official certifying that the applicant organization has a nonprofit status and that none of the net earnings accrue to any private shareholders or individuals.
- (d) A certified copy of the organization's certificate of incorporation or similar document if it clearly establishes the nonprofit status of the organization.
- (e) Any of the above proof for a State or national parent organization, and a statement signed by the parent organization that the applicant organization is a local nonprofit affiliate.

If an applicant has evidence of current nonprofit status on file with an agency of PHS, it will not be necessary to file similar papers again, but the place and date of filing must be indicated.

Previously Filed with: (Agency)

on (Date)

INVENTIONS

If this is an application for continued support, include: (1) the report of inventions conceived or reduced to practice required by the terms and conditions of the grant; or (2) a list of inventions already reported, or (3) a negative certification.

EXECUTIVE ORDER 12372

Effective September 30, 1983, Executive Order 12372 (Intergovernmental Review of Federal Programs) directed OMB to abolish OMB Circular A-95 and establish a new process for consulting with State and local elected officials on proposed Federal financial assistance. The Department of Health and Human Services implemented the Executive Order through regulations at 45 CFR Part 100 (Inter-governmental Review of Department of Health and Human Services Programs and Activities). The objectives of the Executive Order are to (1) increase State flexibility to design a consultation process and select the programs it wishes to review, (2) increase the ability of State and local elected officials to influence Federal decisions and (3) compel Federal officials to be responsive to State concerns, or explain the reasons.

The regulations at 45 CFR Part 100 were published in the *Federal Register* on June 24, 1983, along with a notice identifying the

Department's programs that are subject to the provisions of Executive Order 12372. Information regarding PHS programs subject to Executive Order 12372 is also available from the appropriate awarding office.

States participating in this program establish State Single Points of Contact (SPOCs) to coordinate and manage the review and comment on proposed Federal financial assistance. Applicants should contact the Governor's office for information regarding the SPOC, programs selected for review, and the consultation (review) process designed by their State.

Applicants are to certify on the face page of the SF-424 (attached) whether the request is for a program covered under Executive Order 12372 and, where appropriate, whether the State has been given an opportunity to comment.

