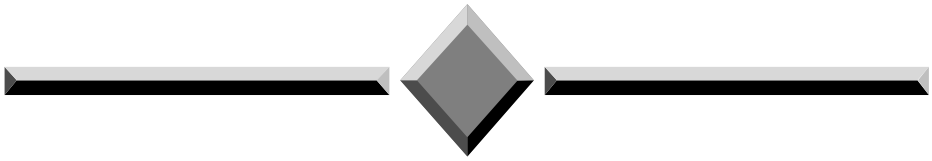

PROJECT HOPE ABSTRACT & NARRATIVE

Project Hope Abstract

Project Hope is a statewide initiative for Rhode Island youth ages 12-18 with serious emotional disturbances who are transitioning out of the Rhode Island Training School for Youth (RITS) back into their own communities. A primary goal is to develop a single, culturally competent, community-based system of care for these youth to prevent re-offending and re-incarceration. Because they have not had access to timely and appropriate mental health and other support services, minority youth are over-represented at the RITS, comprising about 70% of the population. Over 90% of the youth incarcerated at the RITS have either a diagnosed or diagnosable mental health problem; most also have a history of substance abuse prior to incarceration. Project Hope is a partnership between the state's Children's Behavioral Health and Juvenile Corrections systems, building upon the interagency and clinical infrastructure which has been developed in each of the state's 8 mental health catchment areas. CASSP core principles have served as the model for this community-based system of care. The goals, objectives and activities included in Project Hope were framed as a result of an extensive planning process involving RITS youth, family members, state agency staff, and representatives of diverse community agencies and organizations. In addition to core mental health services, this planning group identified several key services necessary to help youth remain in their own communities, including: a network of short term respite homes with trained host home respite providers; daily-contact with the youth, both youth and adult mentors of both genders, and specialized crisis intervention services developed in partnership with local police. These crisis services also will help divert at-risk youth from incarceration. Additionally, in order to meet the multiple needs of this population, strong linkages must be forged with an array of diverse community providers. Some key linkages include: health care (especially substance abuse), educational/vocational services, domestic violence and abuse support groups, recreational programs, and day care services. The capacity of the current statewide system will be expanded to provide these services and linkages. A key project strategy is to engage the youth and their families in planning and implementing transition services as soon as a youth enters the RITS. Family members are key staff for Project Hope, building upon the existing state Family Service Coordinator model. The primary role of the Family Service Coordinators, who are family members with experience parenting a special needs child or adolescent, is to advocate for the child and family, helping them navigate the interagency case review process, supporting the child and family and assuring that Individual Service Plans which meet their needs are fully implemented. All 8 state areas, will receive some additional resources to meet the needs of this population. However, funds will be allocated based on the distribution of the youth across the state. Other funding strategies include pooling state and local resources, and maximizing other funding sources such as EPSDT. Using this approach, it is anticipated that by the end of the five year grant period, the system will have the capacity to meet the need of all transitioning youth in the identified population.

Susan M. Bowler, Ph.D.

Program Narrative

I. Understanding the Proposed Project

Literature Review:

This Proposal, Project Hope, is based on the following underlying assumptions:

1. The majority of youth in the juvenile justice system have unmet mental health needs;
2. For many of these youth and their families traditional service approaches do not work, leading to high rates of re-offending and recidivism;
3. Minority youth are over-represented because they have not had access to appropriate and timely mental health and other support services;
4. Adjudicated youth need to be key decision makers for determining their own needs;
5. Re-offending and recidivism can be significantly reduced for youth with serious emotional disturbances by creating community-based partnerships, that wrap services around the youth and family, using both traditional and non-traditional services and resources;

The high prevalence of mental health problems in adjudicated youth is well documented in a report of the National Coalition for the Mentally Ill in the criminal Justice System, Responding to the Mental Health Needs of Youth in the Juvenile Justice System, (Cocozza, 1992, ed). Cocozza reviewed 34 prevalence studies done between 1975 and 1992 to determine the prevalence of emotional disorders in the juvenile justice population. He found that Conduct Disorder was the most common DSM IV mental health diagnosis with several of the studies reporting prevalence rates up to 90% of the total population. This is the rate reported in a recent survey of the RI Training School for Youth (RITS), the identified population for Project Hope. Schulz & Timmons-Mitchell (1995) found that in a sample of 25 incarcerated youth all had at least one psychiatric disorder, and 88% had a substance abuse disorder.

Not only does this population have high rates of mental health problems, but, most often, offending juveniles, and in particular, offending minority juveniles, do not have access to culturally competent and appropriate community-based mental health services. In Claiming Children, (1992) Jane Adams states, "...the juvenile justice system is almost 20 hears behind most state and community health systems of care. The juvenile justice system is overcrowded, overwhelmed, and over represents low income, racial and ethnic minorities in the juveniles confined" (p.3). This disturbing trend recently was highlighted in a front page New York Times article by Fox Butterfield, By Default Jails Become Mental Institutions, (NY Times, Feb. 22, 1998). In this article, Dr. Linda Reyes, a clinical psychologist who is director of the Texas Youth Commission, was quoted as follows: "Unless you are wealthy and can afford private doctors, you have to get arrested to get treatment." Dr. Reyes further states that incarcerating mentally ill adolescents is "Tragic and Absurd"... "The System we created is totally ineffective. It doesn't rehabilitate the kids and it doesn't even take care of public safety" (NY Times, Feb.,22, 1998). Dr. Reyes goes on to share some disturbing statistics: of the 4,791 juveniles in the agency's custody, 22% suffer from Schizophrenia, Manic Depression or Major Depression. If other DSM IV diagnoses are added, the percentage rises sharply.

Building upon the core CASSP principles of care (Stroul and Friedmen, 1986) for the past decade children's mental health policy makers have recognized the importance of developing individualized wraparound services to prevent more restrictive placements. This approach as been further developed and refined to meet individual needs (Katz-Leavy, Lourie, Stroul & Zeigler-Dendy (1992); Lourie (1994). Success in using this approach for children and youth with serious emotional disorders has been reported by Clark, Schaefer, Burchard, & Welkowity (1992); Yoe, Burnes, & Burchard (1990; and Tighe & Brooks (1995). Coordinating and integrating community-based services is important to promote positive outcomes. Using a comparison group to study the effects of case-managed coordinated services in their Portland, Oregon Partner's Project, Paulson et.al. (in Kutash and Rivera, 1995), reported that the youth receiving these services demonstrated greater individualization of services and coordination and comprehensiveness in service delivery 12 months after enrolling in the project than did a comparison group; additionally, the youth scored higher on measures of social competence; however, no significant reduction in symptoms was reported. In contrast, Kutash and Rivera (1995) report that in a study by Clark et al. (1994) coordinating services did have an impact on the reduction of symptoms.

Juvenile Justice policy makers and researchers also are looking for new ways to avoid restrictive placements for offending and incarcerated youth by meeting their needs within their own communities in a coordinated and holistic manner (What Works: Promising Interventions in Juvenile Justice, Program Report, OJJDP (1994(; (Franz, 1994). Cocozza (1992), states, "Even 'small wins' in interaction contribute to overall system improvements." According to recommendations included in Comprehensive Strategy for Serious, Violent and chronic Juvenile Offenders, Program Summary, a report of the Office of Juvenile Justice and Delinquency Prevention of the US Department of Justice (1993), communities must take the lead role in designing and building services for these youth and their families. Many of the CASSP core principles of care are stressed in this Juvenile Justice report, including support for families, building upon family strengths, case management services, comprehensive diagnostic assessment and evaluation services, the use of mentors, and involving all key providers and support systems, including religious organizations, in meeting the needs of adjudicated youth and their families.

The Oregon Initiative for Reintegrating Adjudicated Youth (Lehman1997) and the Multi-Systemic Therapy (MST) program developed by Scott Henggeler, Ph.D. (in Claiming Children, 1992) are two promising programs which have applied many of the wraparound system of care principles in developing community-based services for offending and adjudicated youth. Crisis intervention services can be a key service component for preventing re-offending and recidivism for high-risk youth (Kutash and Rivera, 1996). The TIES program in Canton, Ohio demonstrated a 90% placement prevention rate (Pastore et al, 1991; reported in Kutash and Rivera). In a Crisis Intervention Service program reported by Goldman (1988), 61% of children returned to their own homes. Project Hope addresses the multiple needs of adjudicated youth with serious emotional disturbances by developing a flexible community-based service system that incorporates

key program elements from documented best practices in both the Children's Mental Health and Juvenile Justice systems.

Service System Needs of Identified Population:
Rhode Island's adjudicated youth and their families have multiple and complex needs. In addition to exhibiting high rates of behavioral and emotional disorders (over 90% have a diagnosed or diagnosable DSM IV disorder), youth incarcerated at the Rhode Island Training School for Youth (RITS) report a history of both individual and family substance abuse. The majority of these youth come from economically disadvantaged urban areas of the state, with high rates of substance abuse, domestic violence, and gang activity. Many have been chronic truants, resulting in poor reading and math skill, with little hope for the future. Additionally, many of these youth, both makes and females, are unwed parents.

Traditional approaches to meeting the needs of these youth and their families have not worked. The number of juvenile arrests in Rhode Island has been steadily increasing from 7,340 arrests in 1991, to 9,766 arrests in 1997 (Governor's Justice Commission Report, 1997). As a consequence of this disturbing trend, increasing numbers of youth, both males and females, are being incarcerated, creating serious overcrowding (RITS census data).

Most of these youth and families have little or no trust in traditional service systems, which either have not been accessible to them or which have not provided appropriate services. In order to transition successfully into their own communities, adjudicated youth must have access to an array of community-based mental health and other support services that are culturally, ethnically, and gender appropriate. In addition, the service system must be family and youth driven and must provide a mechanism for coordinating the multiple services needed by this high risk population. The system also must have the capacity to monitor transitioning youth on a daily basis to address community safety needs.

Rhode Island strongly supports the development of community-based integrated services. This support is reflected in several key planning documents and initiatives including:

- The Reports of the Children's Cabinet and a Special Legislative Task Force
- The Children's Mental Health Plan
- The Three Year Plan issued by the RI Governor's Justice Commission and the Juvenile Justice Advisory Committee
- The DCYF Family Preservation Plan

Rhode Island has been awarded federal grants from both the Children's Mental Health and Juvenile Justice systems to plan and implement integrated systems of care which have a direct impact on this grant proposal:

- Two CASSP system development grants awarded to DCYF from 1991-1996 which supported statewide system planning and implementation for Children's Behavioral Health Services.

- A Comprehensive Strategies Grant, recently awarded to DCYF through the Office of Juvenile Justice and Delinquency Prevention (OJJDP) to provide Training and Technical Assistance to cities experiencing high rates of juvenile crime. This planning initiative will be directly linked to Project Hope planning and implementation efforts in four sites: Providence, Woonsocket Pawtucket/Central Falls and Newport.

- Project REACH RI, a Children's Comprehensive Services Grant awarded to DCYF in 1994 by the Center for Mental Health Services, SAMHSA.

Project Hope builds upon the statewide system of care that has been implemented with REACH RI, a 5 year services initiative grant, that has allowed the state to expand its statewide community based system of care. Funds from Project REACH RI have been used to expand and enhance the interagency and clinical capacity of the statewide system of care in each of the state's 8 mental health catchment areas. The system has been built upon the CASSP principles, which have been the cornerstone of the state's system development. REACH RI is in its last year of funding, and the project has been successfully implemented beyond original expectations. Referrals to the community-based system of care have increased in each of the four project years beginning with 127 referrals in 1994 the first year of implementation, and reaching a total of 625 referrals by the end of 1997.

Referrals come from a variety of sources including, but not limited to, mental health agencies or hospitals (41%), schools (19%), friends of the family (14%), family members (14%), and social service agencies (2%). In all, over 1200 children and families have participated in this interagency case review process. Over 500 families have been enrolled into the Outcome Evaluation component of this project and over 325 agencies have participated in the interagency case review process statewide.

Data and Outcome forms are completed for all children and families accessing the community-based services, including families who are not in the REACH RI Outcome Study. These forms provide invaluable system information documenting both strengths and weaknesses. Following are some promising outcomes based on 6 &12 month data:

- **School attendance and performance improved;**
- **The number of police contacts decreased;**
- **Problem behaviors decreased;**
- **Over two thirds of the families reported they were satisfied with child's progress.**

However, Project REACH RI's extensive evaluation process also helped to identify a significant system gap... youth in the Juvenile Corrections system have not had equal

access to the statewide Children's Behavioral Health system of care, although they have high rates of serious emotional disturbances. Project Hope addresses this system gap.

- Within the last year, DCYF initiated The Partnership for Action program, which is a collaborative effort between the state Juvenile Corrections and Children's Behavioral Health systems to prevent transitioning adjudicated youth from re-offending. This pilot has provided the framework for Project Hope. Three of the state's economically disadvantaged cities, Providence, Woonsocket, Pawtucket/Central Falls and Woonsocket, areas that include a significant proportion of the state's adjudicated youth, are participating in this project which was supported by funds from the RI Department of Health, The Casey Foundation, and REACH RI. These resources have been used to hire additional Family Service Coordinators, family members from minority communities who have experience parenting an adjudicated youth. All youth and their families have access to the case review and wraparound process that is central to project REACH RI. A Transition Coordinator at the RITS, a member of a minority community, coordinates the transition activities. To date over 25 youth and their families have participated in the case review process in these three high-risk areas. Approximately 70% of these youth come from minority families. Of this group of 25, only two have been re-incarcerated. One other youth was hospitalized briefly for a psychiatric illness, thus accessing mental health services which may not have been considered an option previously. Project Hope builds upon this promising project, basing many of the proposed activities and services on the experience of Partnership for Action participants.

Another key component of the state's service system is RIte Care, a nationally recognized managed care initiative for low income children and families. RIte Care, which is administered by the RI Department of Human Services (DHS), provides access to health and mental health services through four approved health plan providers. At present, however, these plans do not provide intensive community-based services to children and youth with serious emotional disturbances. Children and adolescents requiring these services are referred to the Children's Intensive Services (CIS) programs that are the clinical cornerstone of the state's Children's Behavioral Health system of care. Key DCYF and DHS staff have started to address how to include RIte Care eligible children with serious emotional disturbances under managed care. If implemented, Project Hope will provide valuable outcome and process data that will be used to craft the managed care mental health benefit for these youth.

Project Hope expands upon the Partnership for Action pilot project, improving access to mental health services by weaving together existing system strengths, improving and providing appropriate mental health services in the least restrictive environment. There are five Project Hope goals: 1) to prevent restrictive placement by creating a single system of care; 2) to strengthen youth and family participation; 3) to address cultural competency in all system development activities; 4) to provide process and outcome data to inform policy; and 5) to support the system of care with training and technical assistance.

The objectives and activities formulated to meet these goals support the goals articulated in GFA SM 98-006 by creating a single system of care for high-need incarcerated youth with serious emotional disturbances. Additionally, information from this project will provide valuable information about providing community-based services to these youth and their families.

II. Project Approach Plan

You Don't Live on My Street

Ever since the first grade I've been called slow
So I wouldn't give the answer even if I do know.
An' how was I supposed to concentrate
When I can't remember the last time I ate
Do you live every day with defeat?
The you don't even live on my street.

You want to know why I'm not raising my chile?
Well you know I ain't worked in a while.
You want to know why I don't keep in touch?
Is buying some Pampers asking too much?
Can I start coming around the place?
I'm ashamed to let my chile see my face.
Your supposed to get out of the kitchen if you can't take the heat.
So, naw, you don't live on my street.

Until you have been called out of my name
Until you have felt some of my shame
Until you have sold some of my dope
Until you have lost all of my hope
Until you have stood under my rain
Until you have felt some of my pain
Until you have eaten what I've had to eat
Then understand this
You don't live on my street.

These lines, excerpted from a poem written by a 14 year old girl incarcerated at the RITS, poignantly illustrate the multiple needs of adjudicated youth. Project Hope seeks to address these needs by creating a partnership between the state's Children's Behavioral Health and Juvenile Corrections systems at both the state and local levels. Funds will be used to link and augment Children's Behavioral Health and Juvenile Corrections resources, creating a community-based single system of care for a very high-risk population...**youth with serious emotional disturbances who have been adjudicated and who are transitioning back into their own communities.** Through this partnership the system will provide supports and services which will facilitate transition back into the community and prevent re-offending and subsequent re-incarceration.

Rhode Island has eight mental health catchment areas statewide, each of which has a Community Mental Health Center with a full range of children's mental health services. The eight mental health catchment areas and Community Mental Health Centers form the geographic foundation for implementation of Project Hope. Community-based, integrated, and culturally appropriate services for these youth and their families will be implemented in each area according to the unique needs of the area population. All areas will receive some additional support for system enhancement activities; however, Providence, with approximately 40% of the identified population will get the greatest amount of additional resources (see, Allocation of Resources).

Implementation Plan: Year 1

The first six months of Project Hope will be committed to an extensive planning and training process to expand and enhance clinical and interagency capacity statewide. The planning process will involve all state, local, training and program evaluation components of the system of care, including the formation of a task force to plan and implement a coordinated data collection process from MIS of participating sites.

Many core system components are already in place, enabling the state to begin implementation at the end of this initial six month planning process. Within the first two months, funds will be allocated to local areas to enable them to initiate the planning and hiring process. The greatest clinical system enhancement will be in the four areas of the state with the greatest need, Providence, Pawtucket/Central Falls, Woonsocket, and Kent County. A description of the allocation process and the clinical and interagency components of the system of care are discussed in more detail later in this narrative.

Currently the Children's Behavioral Health system includes the following clinical service components statewide: Clinical and Broker Case Management, Emergency Services, Outpatient Services and Assessments, In-home services, Respite, Therapeutic Day Treatment, Therapeutic Foster Care and Wraparound Services. These services are coordinated and integrated through a statewide interagency case review process.

This statewide system capacity will be expanded by: 1) expanding the capacity of the case management services, 2) enhancing the existing Crisis Response capacity by creating the positions of Crisis Coordinator and Assistant Crisis Coordinators, 3) developing a network of respite homes, 4) hiring additional Family Service Coordinators (the backbone of the system of care, 5) hiring new clinical staff to provide supervision to the Family Service Coordinators, 6) developing specialized and expedited case review teams, and 7) developing a statewide network of culturally competent and gender appropriate mentors and advocates.

The enhanced Crisis Response will be a key component of the system of care, as it focuses specifically on the needs of this population, training clinicians, local police and respite home providers in risk and behavioral assessment, family mediation and crisis intervention techniques. This therapeutic, rather than punitive approach, will have a significant impact on keeping youth from re-entering the restrictive environment of the

RITS. Family members will be hired as Assistants to the Crisis Coordinators, providing a vital link between the family members, the crisis response services, and the hosts of the respite homes. Employing family members has been a key system strategy for the system of care, that will further enhanced with Project Hope.

A network of respite homes, beginning in Providence, will be linked to this crisis response capacity, providing short term overnight respite in homes with trained hosts. The lead person for this crisis response will be the Crisis Coordinator, and MSW clinician who will be responsible for managing these services, including recruiting and training crisis workers and respite home providers.

Case Management Services will be expanded, using three different approaches to maximize other funding resources and allow flexibility and choice to participating families: 1) the Children's Intensive Services (CIS) clinicians will be used for youth needing intensive clinical community-based mental health services; CIS services are provided in homes, in schools, or in the community; 2) a broker model case management model will be used for a less intensive need, and; 3) case management services also will be accessed through EPSDT funds and provided by a clinician at a community agency; this could be either clinical or broker model case management services, according to need.

Additional MSW clinician hours will be purchased by local sites to supervise the expanding pool of Family Service Coordinators and to coordinate activities at he local level. In the first year, all the core service components will be put into place in Providence; each of theses components will be expanded in year 2-5 to meet the increasing numbers of youth and their families who are entering the system.

The Clinical/Service capacity of the system will be expanded as follows:

- A Crisis Coordinator will be hired in Providence
- A network of 45 respite homes will be developed in Providence
- A statewide network of mentors will be trained
- A total of 4 Clinical Case Managers will be hired in Providence, Woonsocket, Pawtucket/Central Falls, and Kent County
- A total of 4 Broker Case Managers will be hired in Providence, Woonsocket, Pawtucket/Central Falls, and Kent County
- Case Managers, funded by EPSDT, will be hired in Providence, Woonsocket, Pawtucket/Central Falls and Kent County as needed
- Additional wraparound funds will be allocated to each local site
- 1.5 FTE MSW for supervision at the local level will be hired

The Interagency Infrastructure of the system will be enhanced as follows:

- A total of 6.5 FTE new minority Family Service Coordinators will be hired for Providence, Woonsocket, Pawtucket/Central Falls and Kent County
- Juvenile Corrections staff and local police will be actively recruited to membership in the state's 8 interagency Local Coordinating Councils
- Uniform procedures for youth transitioning to the community will be developed

- All forms for participation in case review and Outcome Evaluation will be modified as indicated
- Specialized and expedited case review teams will be developed in all 8 areas
- Two part time Site Coordinators will be hired for Pawtucket/Central Falls and Providence to facilitate project enrollment
- A family support group will be established at the RITS and 4 new support groups established statewide
- Formal Memoranda of Agreement will be developed with key local agencies
- Culturally Competent contracts will be signed with local coordinating agencies
- Local interagency coordinating councils will receive additional financial support

Training and Technical Assistance support will include:
- Revising current Training & Technical Assistance Plan
- Training on recruiting mentors, as well as and training both youth and adult mentors
- Training respite home hosts in crisis intervention techniques, family mediation, and behavioral risk assessment
- Training local teams on meeting the diverse needs of the identified population and creating local minority support networks
- Creating a new training module for interdisciplinary training program (implemented in second half of year one)
- Creating informational networks with diverse populations
- Increasing statewide pool of multi-lingual interpreters and materials
- Linking with training's offered by other systems (especially relating to IEPs/Special Education services and Medicaid)
- Training of utilizing EPSDT
- Developing a calendar of available training's statewide

Families will be referred to Project Hope in month 7 of the first year, and the enrollment process in Project Hope will begin for the first cohort of 95 participants (see enrollment process below).

Year 2:

In Year 2, the system will be at full implementation. The local sites will receive additional resources to support clinical services, the interagency case review process, wraparound services, and other local system enhancement activities proportionate to need. Year 1 data will be reviewed to assess the system of care and to assure appropriate allocation of resources based on census data. The Children's Behavioral Health Advisory Committee, which includes local representation, together with the Project Director will be responsible for coordinating the ongoing planning and allocation process.

The following implementation plan for Year 2 is based on current data:
- 3 additional clinician/case managers will be hired
- 3 broker case managers will be hired
- An additional MSW Crisis Coordinator will be hired statewide
- 2 additional Assistant Crisis Coordinators will be hired (family members)
- 55 new respite homes will be established statewide

- New case review teams will be developed as needed
- A network of adult and youth mentors will be operational statewide
- An additional 2.5 Family Service Coordinators will be hired (total of 9)

Year 3-5:
In each of the Year 3-5 the same planning and allocation process will take place. Funds will be allocated proportionately to local sites for support of local case review and system enhancement activities. Staffing will be enhanced to meet the needs of increasing enrollees with the following Full Time Equivalents (FTEs):

	Year 3	**Year 4**	**Year 5**
CIS Case Managers	add 3 (T=10)	add 2.5 (T=12.5	add 2.5 (T=15)
Broker Case Managers	add 3 (T=10)	add 2.5 (T=12.5)	add 2.5 (T=15)
(EPSDT)	as needed	as needed	as needed
Fam Serv Coord	add 2.5 (T=10)	add 2.5 (T=12.5)	add 2 (T=15)
MSW Crisis Coord.		add 1 (T=3)	add 1 (T=4)
Asst. Crisis Coord.	add 1 (T=3)	add 1 (T=4)	add 1 (T=5)
MSW Supervision	add .5 (T=2.5)	add .5 (T=3)	add .5 (T=3.5)

Additionally, in Year 3, a pilot Managed Care project for this identified population will be implemented, expanding the current state managed are program, RIte Care (discussed in Section I), to include children and youth with serious emotional disturbances.

DCYF and DHS (the state Medicaid Authority) have begun the initial planning process for this program, which will include youth at the RITS. At present, these children and youth with serious emotional disturbances have access to intensive community-based services through the state's Children's Intensive Services program (see below). The data collected from years 1 & 2 of Project Hope will be used to inform the managed care planning process about effective service approaches.

Financial Strategy
Four primary strategies will be used to maximize available resources: 1) pooling Children's Behavioral Health and Juvenile Corrections resources; 2) allocating resources according to need; 3) preventing duplication of services; and 4) accessing and maximizing funding sources such as EPSDT and other available Federal and State funds.

Pooling Resources
Match funds for Project Hope will be allocated from the Department of Children, Youth and Families (DCYF), the RI Department of Education (RIDE), and the RI Department of Health (DOH, Substance Abuse). In each of the 5 years, the RIDE and the DOH will allocate $100,000 and $21,000, respectively. DCYF will provide additional match funds.

Allocation of Resources
This is a statewide initiative. Accordingly, each of the state's eight interagency Local Coordinating Councils (LCCs) will receive some financial support from this grant to enable them to participate in the project. However, allocation of funds will be

proportionate to the indicated population. All of the state's community-based initiatives are based on the philosophy that funds should follow the state's children and families, thus enabling local community members to be pivotal decision-makers in allocating resources and policy-making. This commitment to helping local communities support their own children and families, will be continued in Project Hope by allocating resources according to demonstrated need. Rhode Island Training School for Youth (RITS) census data of the past year (1996-1997) will be used to determine allocations. Following is the anticipated Year 1 distribution of 150 families:

Mental Health Catchment Area	% of RITS Population	# of Youth
Providence	41	60
Pawtucket/Central Falls	17	25
Northern RI (Includes Woonsocket)	13	20
Kent	10	15
Metro	6	9
East Bay	5	8
Newport	5	8
South Shore	3	5
	100%	150

Accessing and Maximizing Funding Sources

The interagency infrastructure established through Project REACH RI has been an extremely effective mechanism for identifying new resources and funding. Through Project REACH RI's local and state collaborative efforts, communities have been able to access substantial new resources and maximize funding opportunities. For example, at the outset of Project REACH RI, individualized Medicaid/EPSDT Scripts, which provide funding for customized one on one mental health and social service supports (including case management) were not understood and were not accessed by the system of care for eligible youth and families.

Project REACH RI provided extensive training on the use of EPSDT to the Local Coordinating Councils, and funding through state Medicaid resources for 250 individualized scripts now amounts to more than $3 million annually. Health and other health and supportive services, which will be funded through EPSDT, include: emergency services, diagnostic assessment and evaluation services, outpatient services, case management, intensive in-home services, substance abuse services, general health care services, and skill development services. The Department of Human Services, the state Medicaid authority, and DCYF work collaboratively to assure that the State match is available to fully support access to these Federal funds. It is anticipated that Project Hope will similarly use Medicaid dollars to create an infrastructure for Juvenile Corrections that can leverage substantial new community resources; the system of care will also focus heavily on the rights and entitlements of youth under IDEA/Special Education where resources as substantial as those associated with EPSDT can be harnessed to service these youth and their families. Incarcerated youth cannot receive Medicaid funds; therefore a process is being developed between DCYF and DHS, to assure access to these funds without delay upon transition.

Existing cross systems training including those funded by Title IV E, Title IV B, and the RI Department of Education (IEPs, Advocacy, and Transition to Independent Employment) will be made available to Project Hope participants. Additionally, on-going Training and Technical Assistance activities will be co-funded by the RI Department of Education.

Preventing Duplication of Services:
A key strategy for implementing this grant proposal is to develop community-based, diverse service networks which build upon the existing mental health, juvenile corrections, and other community resources currently available in each area. Local networks of grass roots advocates, businesses, churches, and non-traditional local service providers will be linked with more traditional services and service providers to provide the flexibility and choices necessary to meet the needs of adjudicated youth and their families. To avoid duplication, all services will be coordinated through the local case review process, which is an integral part of the state's system of care interagency infrastructure. Case review teams will develop an Individual Service Plan (ISP) for each youth and his/her family.

A commitment to respecting and addressing the cultural diversity of the youth and families in this target population is central to all of the state's system development activities. Building upon this diversity, the proposed project will focus on developing a flexible and responsive system, providing opportunities for youth and their families to make choices based on their own culture, ethnicity, language, and gender. The project will build upon the underlying CASSP principles, which have guided all of Rhode Island's children's mental health system development activities, creating a model for family involvement and decision making at the local level that further enhances these principles. Local communities will be provided training and technical assistance to support these activities.

Project Sustainability
Rhode Island has a demonstrated history of sustaining a system of care established with the support of Federal funds. Project REACH RI, the statewide Children's Behavioral Health initiative which forms the foundation for the proposed initiative, Project Hope, will be fully supported by state dollars and federal Medicaid dollars when grant funding has ended. All the clinical and interagency services and programs established through REACH RI funds will remain in place.

DCYF has made the same commitment for Project Hope. All services and programs implemented with the support of this Federal grant initiative will remain in place, as core components of the state's community-based interagency system of care.

To Summarize The implementation plan is built around some key financial strategies which include: allocating resources according to need, pooling resources, accessing and maximizing existing state and local resources, and avoiding duplication of services. This strategy will form the foundation for continued system growth.

Goals, Objectives and Action Steps:
The following Goals, Objectives, and Action Steps have been formulated:

Goal 1: Prevent restrictive placement for transitioning adjudicated youth with serious emotional disorders and their families by creating a single, integrated, community-based system of care; the system of care will offer a full array of timely, coordinated and appropriate services which are provided in a least restrictive, cost-effective and culturally, ethnically, linguistically, and gender appropriate manner.

Strategy: Enhance and support the statewide clinical & interagency infrastructure.

Objective 1: Reduce current rates of recidivism: cut by 15% in Year 1 (from 66% to 50%); cut by 25% in Year 2 (to 41%); and cut by 50% Years 3-5 (to 33%).

Activities:
1. Recruit, train, and hire additional Family Service Coordinators according to need.
2. Develop specialized & expedited case review teams for target population.
3. Identify daily contact person for each participating youth
4. Increase funding to LCCs to support outreach, advocacy, training & supervision.
5. Hire Crisis Coordinator in Providence and develop respite homes.
6. Fund additional clinical & broker model case management services according to need.
7. Allocate funds to LCCs for respite, recreational, and wraparound services according to distribution of population.

Objective 2: Increase # of referrals to Children's Behavioral Health System

Activities:
1. Develop procedures with RITS staff for transitioning youth.
2. Add Juvenile Corrections representatives to state and local networks.
3. Invite Juvenile Corrections staff to interdisciplinary training's.
4. Include Juvenile Corrections staff in local, state, and federal mental health meetings.

Goal 2: Strengthen participation of youth and families at all levels of individual and system planning, implementation, and evaluation.

Strategy: Develop process for recruiting youth and families

Objective 1: Establish process for early and on-going communication with families

Activities:
1. Develop informational materials in major languages & distribute statewide.
2. Develop process with RITS Transition Coordinator for early contact with youth and family members; utilize all opportunities for contact when families are at the RITS.
3. Make all relevant forms "user friendly" noting special needs and cultural preferences.

4. Include youth and family members as team members to attend state and federal mental health meetings.

Objective 2: Create and support pool of family advocates for these youth and families

Activities:
1. Develop family support group at RITS and add 4 new support groups statewide.
2. Develop a pool of mentors, including community members who are natural helpers.

Goal 3: Address cultural competency in all system development activities

Strategy: Build upon existing cultural strengths and support systems

Objective 1: Institutionalize cultural competence

Activities:
1. Require local sub-contractors to hire minority and bi-lingual staff and to contract with minority service providers in the communities.
2. Recruit additional interpreters who have experience in Juvenile Corrections.
3. Develop Memoranda of Agreement with state and local agencies serving minority populations to formalize their participation in Project Hope.
4. Have all forms translated into Spanish, Portuguese, and Creole; develop capacity to have forms translated into other languages as indicated.

Goal 4: Provide both process and impact information on outcomes to inform local, state, and national system development policies.

Strategy: Use data to make informed allocation and policy decisions.

Objective 1: Develop new forms or modify existing forms to meet project needs.

Activities:
1. Develop a new Outcome and Data form; revise other forms as needed
2. Hire two additional .5 Site Coordinators.
3. Review quarterly/annual reports and RITS census data to assess progress of project and to determine appropriate allocation of funds.

Objective 2: Coordinate cross systems MIS data

Activities:
1. Form committee to coordinate interagency MIS data.
2. Use data from year 1 & 2 to form funding guidelines for a pilot Managed Care initiative which will be implemented in Year 3.

Goal 5: Support the expanded system of care with Training & Technical Assistance

Strategy: Access existing cross systems training & developing new training opportunities

Objective 1: Adapt interdisciplinary training to meet needs of expanded system

Activities:

1. Develop new module with youth, family members, Mental Health, and Juvenile Corrections staff
2. Recruit family member and/or youth to be co-trainers.
3. Develop culturally appropriate training materials for training module for existing interdisciplinary training program.
4. Recruit family members, Juvenile Corrections staff, minority providers and advocates to participate in training's.
5. Incorporate new module into existing interdisciplinary training.

Objective 2: Develop specialized state wide training's to support youth & families

Activities:

1. Train both male and female adjudicated youth & community members to be mentors.
2. Conduct regular statewide training's on specialized and expedited case reviews.
3. Revise current Training and Technical Assistance Plan.
4. Develop cross system training calendar for IEPs, other Special Education, and transition services.
5. Train crisis & respite providers in crisis intervention, family mediation, and risk assessments.
6. Conduct training's on use of EPSDT.

TARGET POPULATION

Project Hope will serve youth with serious emotional disturbances who are transitioning back to their communities from the Rhode Island Training School for Youth (RITS), the state's only secured facility for adjudicated males and females 12-18. Every youth who will be enrolled in the project will meet the eligibility criteria for the Children's Mental Health Initiative, GFA No. SM-98-006 as follows:

Age: Youth will be under 22; the ages will range from 12-18.

Diagnosis: Client will have the presence of an emotional, behavioral, or mental disorder diagnosable under DSM-IV or their ICD-9-CM equivalents or subsequent revisions (with the exception of DSM IV "V" codes, substance use disorders and developmental disorders, unless they co-occur with another diagnosable serious emotional disturbance).

> Based on a recent survey, the most prevalent diagnoses will be Post Traumatic Stress Syndrome, Attention Deficit Hyperactivity Disorder (ADHD), Obsessive Compulsive Disorder, Depression, Oppositional Defiant Disorder and Conduct Disorder; many youth also will have co-occurring substance abuse disorders.

Disability: Inability to function safely in their own homes, schools, and communities.

> All of the youth who are enrolled in this project, by definition, have demonstrated an inability to function safely in their own homes, schools and/or communities. All are at serious and imminent risk of re-incarceration due to their complex service needs.

Multi-Agency Need: In need of Multi-Agency services:

> Only incarcerated youth who require services from a variety of providers will be enrolled in the project. Transitioning incarcerated youth who go into residential placement or who do not require services from a variety of providers will not be referred to Project Hope.

Because they come from poor communities and have not had access to appropriate mental health, health, education and other social services, youth from the state's minority groups are disproportionately represented at the RITS. Between 60% and 70% of the residents are from minority groups. Only 31% are White. In contrast, 92% of the overall population of the state is White (Hodgkinson, 1997). Thirty-five percent of the RITS youth are African American, 20% Hispanic; 5% Asian, and 7% other. Over 80% of these youth come from Providence, Pawtucket/Central Falls, and Woonsocket, cities with high rates of substance abuse, poverty and family violence, high risk factors for juvenile crime (RITS census date).

According to RITS census data/DCYF MIS system and youth surveys:

- One-fourth of the residents are female
- 90% of youth and 65% of families have a history of drug abuse
- 90% are school dropouts; the mean reading level is 5th grade; and over 65% are eligible for Special Education Services
- Many, both males and females, are unwed teen parents
- Many report poor relationship with their family members
- 50% have been victims of serious abuse and neglect
- Most females, have been victims of sexual abuse and domestic violence
- A large number re-offend and return to the RITS (ca. 66% recidivism rate)
- All report a history of failure; many report they have no hope for a future life

Service Needs of Identified Population:

A multi-faceted process was used in determining the service needs for the identified population and their families including:

- RITS youth participated in the planning and also surveyed all other residents
- Focus groups were held with parents and youth
- A series of community based planning meetings were held with youth, families, Partnership for Action members, staff from DCYF Child Welfare and Juvenile Corrections, and representatives from local minority and alternative services agencies
- Personal interviews were conducted with:
  Family Service Coordinators

Family advocacy/support group members
Case review team members
Providers of alternative services
Probation and Parole staff
Family Court staff
The Superintendent of the RITS
The Chief of Children's Behavioral Health, DCYF
The DCYF Family Preservation Coordinator

Based on the profile of the target population described above and on this intensive planning process a wide range of needs in addition to the pivotal and basic mental health services were identified including, but not necessarily limited to:

- Specialized crisis response services
- Specialized respite homes accessible to youth's school
- Substance Abuse Services and other health care services
- Domestic Violence/Abuse Prevention Services
- Services for pregnant and parenting teens
- Day care services and parenting classes
- Educational services, especially access to literacy programs
- Vocational services and job training and placement
- Transition services, both transitioning to adult mental health system and transitioning to becoming a competent adult in the community
- Recreational services
- Daily contact with the youth
- Mentors, both adult and youth

Local communities also have safety needs which must be addressed if these youth are to be successfully transitioned from the RITS to their own neighborhoods. This concern is being addressed by linking the Children's Behavior Health system with the Juvenile Corrections system. All the Parole and Probation services that currently are in place to assure community safety will remain. Additionally, Juvenile Corrections is developing a graduated sanctions program and an electronic monitoring system for high risk youth. Project Hope services will augment these services by providing community-based linkages, affording the community even greater protection. For example, every youth will have daily contact (provided by the Case Manager or mentor) for as long as it takes to successfully re-integrate these youth.

Prevention of Serious Emotional Disturbances

Although this is primarily a project focusing on high risk youth who already have demonstrated a serious emotional disturbance, the community-based system that will be developed with grant resources will also provide a mechanism for early identification and treatment of high risk youth, facilitating access to timely and appropriate community-based mental health system. As discussed in the section of financing, this will be a flexible and expansive system that is developed by creating strong community linkages and tapping into existing resources. On-going and comprehensive Training and Technical Assistance will support this whole system development approach. Two key

components of Project Hope will have a direct effect on prevention of serious emotional disturbances:

1. The extensive Training and Technical Assistance program will include state and local law enforcement and Juvenile Corrections staff; this will increase their understanding and knowledge of children's mental health issues, and provide information on accessing mental health services in a timely and appropriate way;
2. The crisis intervention services and respite homes that will be developed will not only be available for the identified population, but also can be used preventively to diffuse a crisis at home, school or the community. Crisis workers will be a resource to local police, helping to address potential high risk situation early in the process, so that the appropriate mental health, and other needed services can be accessed.

Enrollment Process

There are about 900 adjudicated Rhode Island youth, including males and females, residing at the RITS annually. Of this number, about 10% are transitioned to residential placement from the RITS, and another 10% leave the state. Project Hope participants will be identified from the remaining pool of about 700 youth who will be released by order of Family Court, which bases release on an internal risk assessment, as well as the youth's legal status, prior history and current behavior at the RITS.

The enrollment process will be the same as that which was established for REACH RI, which enrolled 501 children and families statewide in the Outcome Evaluation. Families first were approached by a Family Service Coordinator who explained the case review process and facilitated the referral process. Once families had had an initial case review, the Outcome study research project was explained to them, and they were asked to participate. About 85% of the families who had an initial case review agreed to be a part of this study. A large number of incarcerated youth and their families have not had positive experiences dealing with systems of care and often are extremely dubious about the effectiveness of mental health services. The long path which has led to incarceration has been filled with barriers and pitfalls. Consequently, it is anticipated that enrollment into the Project Hope Outcome Evaluation may be lower than in REACH RI.

In order to ensure that the enrollment target will be met --- that 95 youth and families will be enrolled into the project in Year 1 --- a minimum of 150 youth and families will be asked to participate in the case review process. In Year 2, and additional 150 youth and families will enter the system, and in Year 3, about 105 families will be asked to participate in the case review process to assure reaching the enrollment target of 65.

It is important to note that by using this method of enrolling families into the Outcome Study, many more families than those actually enrolled will have access to the community-based system of care. Project REACH RI enrolled 510 families into the Outcome Study; however, because of the expansive infrastructure created with the support of REACH RI funds, over 1200 children and families accessed the case review process statewide (and process data was collected for all of these youth).

System growth resulting from the interagency infrastructure that has been established statewide has proven to be an extremely effective mechanism for identifying new resources and funding. Through local and state collaborative efforts, communities have been able to both identify additional services and resources and maximize funding opportunities. For example, as mentioned earlier, there has been extensive training on the use of EPSDT, to meet the service needs of children and families with serious emotional disturbances. It is anticipated that Project Hope will build upon this foundation, increasingly expanding the system's capacity to provide integrated, community-based services for the identified population.

The number of case reviews for the identified population will increase incrementally each year, as many of these youth and families will stay connected to the Project for several years or until they age out (age 18). It is projected that the following number of youth and families will access the interagency case review system in each of the five project years: Year 1: 150; Year 2: 225; Year 3: 300; Year 4: 375; Year 5: 450; for a total of approximately 1500 case reviews. As Project Hope begins to reduce recidivism rates, it is expected that the system will be able to provide these community-based services for all youth in the identified population.

APPROACH TO SERVICE INTEGRATION

The Children's Cabinet

The Children's Cabinet is a statutorily body charged by RI General law with meeting at least monthly to coordinate and problem solve around all state policy and procedure issues involving services to children and their families. The Department is chaired by the Governor or, in his absence, by the Director of the state Department of Administration. Members include all departments with policy or financing responsibility for child and family service. In addition to the state level departments, the RI Family Court is also a member of the Children's Cabinet. This body both enters into interagency agreements to support integration of policy initiatives (the Cabinet document recognizing and specifying each agency's responsibilities in the system of care, as well as the legislation charging the Cabinet are in Appendix 1) and also resolves issues on a less formal basis.

DCYF Intra-agency Collaboration:

Children's Behavioral Health is one of three divisions within the Rhode Island Department of Children, Youth and Families. The other two major divisions are Child Welfare and Juvenile Corrections. As a consolidated children's services agency, the DCYF has the capacity to plan and develop services across division lines. Child Welfare and Children's Behavioral Health have made great progress in establishing strong linkages in their service systems. All service planning and implementation is developed collaboratively with DCYF staff. Federal funds (REACH RI) have been used to hire community-based clinical case managers to meet the needs of children in the care and custody of DCYF. These children have greatly benefited from the single system of care approach resulting from this collaboration. Collaboration between the divisions of

Juvenile Corrections and Children's Behavioral Health has intensified in recent years, strengthening and enhancing joint planning and system implementation efforts.

The Children's Behavioral Health Advisory Committee

The Children's Behavioral Health Advisory Committee, comprised of representatives of all the local sites and key staff from all the state child and family serving agencies will have oversight of Project Hope. This Advisory Committee, which has been in existence since DCYF was awarded the first CASSP grant in 1991, has been co-chaired by a parent and a professional since it first was established. An Executive Committee meets monthly to set the agenda and to address urgent issues; several task forces, including the Service Development Task Force, also meet to address system development issues. Advisory Committee members review the progress of current Children's Behavioral Health initiatives, discuss interdepartmental issues, and make recommendations to the Chief of Children's Behavioral Health who attends these monthly meetings. These recommendations are then brought to the attention of the Director of DCYF. Advisory committee members also are active advocates for issues relating to children's behavioral health and the community-based, integrated service system.

The State Level Multi-Agency Review Team (MART)

Additional state level support is provided by a Multi-Agency Review Team (MART) which reviews issues that cannot be resolved locally. The Director of Special Needs Populations at the Rhode Island Department of Education has chaired this committee for the past several years, demonstrating his strong commitment to this interagency process. The MART is the state level "Barrier Breaker." These referrals trigger discussions of interagency issues which lead to significant interagency system changes.

Local Coordinating Councils

Each of the state's 8 mental health catchment areas has an established Local Coordinating Council, (LCC) which is the coordinating body for local interagency system development. LCCs are comprised of a wide range of family members and community representatives from both the public and private sector. All local service and school systems, networks, family groups and agencies concerned with children and families are recruited for participation in this network. Each of the LCCs appoints a Chairperson and selects a fiscal agent, a community agency responsible for oversight of all interagency expenditures. In Providence, this role has been assumed by a diverse inner city community agency. In the 7 other areas, the Community Mental Health Center functions as the fiscal agent. Each current fiscal agent has made a commitment for continued support for Project Hope (see Assurances, Appendix I).

Local Multi-Disciplinary Case Review Teams

The interagency case review process, which began with the first CASSP grant in 1991, now has become an integral component of the system of care. Case review teams develop an Individualized Service Plan (ISP) for each child and family. Children, youth and their families are crucial decision makers in developing their own ISPs, which are built around family strengths, cultural preferences, and service choices. The case review process provides the mechanism for integrating and accessing services from a range of

community providers and organizations, including, but not limited to: educational, transitional, child welfare, mental health, health, substance abuse, juvenile justice, and vocational training agencies. To date, over 1200 initial case reviews have been conducted statewide. Re-reviews are held as needed. Since instituting this process, out-of-state placements have been reduced by over 50%. Referrals come from family members, schools, other service systems and local agencies. Specialized and expedited case review teams will be developed to respond to the specific needs of the identified population, building upon the solid experience and expertise of the current case review teams. Data collection procedures and forms have been developed for use by all case review teams. This has helped to institutionalize the process statewide. Having uniform procedures also helps assure that services will not be interrupted when youth and families move to a different area of the state. Representatives from all eight areas participated in developing these forms to assure that they meet the needs of the state's diverse population. This same process will take place with Project Hope.

Case Management

Based on the underlying assumption that the youth and their families who will be enrolled in this project have major strengths to build on and are the experts about what will work for them, no one case management model will be imposed. Rather, the flexibility which has been built into the current system will be continued, allowing case management services to be tailored to meet individual needs. Local areas will be required to hire additional staff who are representative of their racial and ethnic populations.

Every youth and family will have access to a case manager to assist in coordinating and integrating services. Both broker model and clinical case management services will be available. Case managers will be identified at the initial case review and will remain engaged with the youth and family until services no longer are indicated. Case Managers will have caseloads no greater than 10 youth to every 1 case manager. As discussed previously in the Implementation Plan, three approaches will be used to provide case management services: CIS clinicians; broker case managers; and either clinical or broker case managers funded by EPSDT and provided by local agencies. The less intensive broker model case management services will also be available by linking with existing Juvenile Corrections; the LCC case review process will function as the service integration mechanism.

Family Service Coordinators

Family Service Coordinators are the backbone of the state's Children's Behavioral Health system. Family Service Coordinators are family members who have had experience parenting or advocating for a child with special needs. Depending upon the individual circumstances, the role of a Family Service Coordinator may vary. Their pivotal role, however, is to be a primary advocate for the child and family, helping to navigate the system of care, coordinating the case review process and providing help and support to the child/youth and family. Presently, there are 17 Family Service Coordinators in the 8 sites across the state. The Family Service Coordinators are a diverse group, who are members of several of the state's ethnic minorities. Currently, several of the Family Service Coordinators are bi-lingual in Spanish and/or Portuguese, languages frequently

spoken by Rhode Island's minority populations. As the Rhode Island system of care has matured, local communities have increasingly demonstrated that there is a rich untapped pool of family members who can become key system change agents. This position has proven to be a step on the ladder for career advancement for several family members who have been hired. All are provided on-going training and supervision, enabling them to hone their skills in a supportive environment and develop confidence to become effective advocates. The Family Service Coordinators, who will be hired in Project Hope, will be family members who have experience with the Juvenile Corrections system and who are from a minority culture in their local area. Recruiting bi-lingual Family Service Coordinators will be a top priority. Project Hope funds will be used to purchase additional MSW clinician hours to provide on-going supervision to the new Family Service Coordinators and help coordinate the interagency activities at the local sites.

Family Advocacy

The Parent Support Network (PSN) of RI has been a supportive partner in all of the state's Children's Behavioral Health system of care activities. Initial support for PSN was provided by a CASSP grant. Recognizing that a strong family support organization provides invaluable assistance in planning and developing community-based, family-focused services, DCYF has institutionalized its commitment to PSN by building family support into the Children's Behavioral Health budget. The allocation to PSN has grown over the past several years, to support PSN's scope of programs and services. Currently PSN receives state and Project REACH RI funding to support this vital partnership with family members.

Several other parent support groups in the state have made significant contributions to the Children's Mental Health service integration process. The RI parent Information Network (RIPIN), the RI Foster Parents Association, AmiCan, Ch.A.D.D., Parents Anonymous, and PSN, have collaborated with the RI Training and Technical Assistance Project (RITAP) on the Training and Technical Assistance Task Force to develop a program that provides technical assistance on all facets of family involvement and service integration. A Training and Technical Assistance Plan is reviewed and modified annually to meet changing system needs. A core system integration component which this Task Force established is a cadre of multi-lingual translators knowledgeable about children's mental health.

The Director or other staff and volunteers at PSN and RIPIN participate in every facet of system planning, implementation, training, and evaluation of the system of care both a the state and local levels. PSN members are part of state teams that attend local, regional and national system of care trainings and conferences. Through the involvement of these family advocacy organizations in the Project Hope planning process, several family support initiatives described in the Goals and Objectives section, have been identified to strengthen participation of adjudicated youth with serious emotional disorders and their families.

Training and Technical Assistance

Two training components of the system of care include:

1. The Training and Technical Assistance Task Force administered by the RI Technical Assistance Project (RITAP), is funded by Project REACH RI and the RI Department of Education to provide assistance to local sites. Each year the task force reviews its annual plan, revising it to meet new system needs. Family members from the state family advocacy groups have been recruited and trained by PSN, RIPIN, and the Director of RITAP, Dr. Tom DiPaola, to work with the local sites. A major training component is helping sites become more culturally competent.
2. Funds from the state's second CASSP grant were used to develop an interdisciplinary training for family members and providers, focusing on children's mental health issues. This program, administered by the RI Council of Community Mental Health Centers, has proven to be enormously successful in promoting system integration by involving many people from across systems (425 to date). This is a four day training that is held twice a year; 3 of the 9 training modules focus on Cultural Competency, Transition Planning and Legal and Client Rights. Both family members and professionals co-facilitate these trainings. This is a permanent component of the system of care which will be enhanced to include training specific Juvenile Justice.

RITS Transition Planning

The RITS transition process will be a major link between the Juvenile Corrections System and the Children's Behavioral Health systems, providing a solid building block for system collaboration. **Connecting the youth with their families in transition process is paramount**. Youth who participated in planning this proposal, emphasized that if *they* had a positive attitude about transition planning, their parents would be much more likely to get involved. As one youth noted, "My mother heard them all say in Court that I'm bad and it hurt her. She doesn't want to hear it from you. But if she hears I trust you, she'll try again *for me*." Starting transition planning as soon as possible is key to the success of this project for several reasons:

1. There must be time to establish a supportive and trusting relationship with these youth and their families.
2. Many of these youth and families have lost hope, as the young girl's moving poem so poignantly illustrated. Involving these youth and their families in transition planning from the earliest possible opportunity, creates an opportunity to plan for life beyond the chain link fence.
3. Time is required to identify and implement community-based services, and local school must become involved.

The RITS has developed a well-functioning internal capacity to initiate the transition process. Several key RITS staff are involved, including the Clinical Director, the Director of Special Education, the Director for Program, and a .5 FTE Transition Coordinator, who is a minority family member from Providence. Additionally, the RITS is hiring a Family Service Coordinator, who is also a minority family member, to coordinate the Special Education services at the Training School with community Special Education Services. Within 30 days of admission, a thorough evaluation is conducted, including psychological testing, an educational assessment, medical history, family

history, and social history. The RITS is a state licensed Special Education facility with the capacity to develop Individual Educational Plans (IEPs) for youth. Both the youth and the family are invited to participate in the transition planning meeting to help identify needs and develop initial plans.

As soon as a youth is admitted to the RITS, the Transition Coordinator invites the youth and family to participate in an interagency case review. Once they agree, they will be contacted by a Family Service Coordinator, who will explain the process, assure confidentiality, and ask the parents to sign the necessary consent and release of information forms. A referral form will be filled out to start the interagency process. Family Service Coordinators will meet with the family in their homes, at the RITS, or at another place selected by the family.

An initial case review meeting will be scheduled at least six weeks before release. If there is an unexpected release date, an expedited case review will be called. All teams and Family Service Coordinators will be trained in conducting expedited case reviews. Meetings, including the adjudicated youth and their families, will be held in the local community whenever possible. This approach has been very successfully implemented in the Partnership for Action project.

CLINICAL SERVICE COMPONENTS

CIS:

Children's Intensive Services (CIS) forms the clinical infrastructure for the state community-based system of care. Each of the state's Community Mental Health Centers has a CIS program and a Director of Children's Services. The capacity of CIS will be expanded with funding from Project Hope to include youth from the identified population.

All children and youth in the CIS program have a clinical case manager with a case load no greater than 6/7 children to one clinician. The CIS services are linked to other community services through the local interagency case review process. CIS Services provided at home, in the school, or in other community locations, include:

- Emergency services to assess the need for hospitalization
- Assessment and Evaluation Services (both psychiatric and psychological)
- Medication monitoring
- Group and Individual Outpatient Counseling
- Family counseling
- Respite services
- Linkages to other community-based services

Project Hope participants also will have access to a wide range of clinical outpatient services provided by community agencies funded by Medicaid or another insurer.

Crisis Response

All of the CIS programs have 24 hour a day, 7 day a week emergency services for children and their families. This capacity will be expanded in Project Hope to include a statewide specialized crisis response capacity for the identified population. MSW Crisis Coordinators, trained in family medication, crisis intervention, and behavioral and risk assessments will be hired to manage this specialized crisis response. Family members will be employed as assistants to the Crisis Coordinator, following on-going policy of strengthening and enhancing the system of care by hiring family members. The crisis response will involve on-going collaboration with local law enforcement officers, providing them the help they need in identifying mental health problems and accessing appropriate services. Crisis workers will respond to requests of local law enforcement officers, providing services wherever they are needed in the community to prevent more restrictive placements. This will be a 7 day a week, 24 hour a day services.

Out-of-Home Respite

The experience of families enrolled in Project REACH RI has demonstrated a system need for short term (often just overnight) respite services to support care givers. Funds from Project Hope will be used to develop this capacity both for use in crisis situations and for planned respite. The Crisis Coordinators will be responsible for recruiting and training respite home providers. These homes will provide short term (under 21 days) specialized respite services. Respite homes will be located in local communities to assure continuity of schooling and will be representative of the state's diverse cultures.

In-Home Respite

Currently, each local area has access to a pool of respite providers who are funded by Project REACH RI. This pool of funding will be available to provide in-home respite services to Project Hope families.

Day Treatment

There is a network of specialized day treatment programs across the state that have been established with state, local, and federal children's mental health funds. Four of these programs have been established with Project REACH RI funds and have become integral components of the state's system of care. These statewide specialized Day Treatment programs provide individualized and flexible services tailored to meet the child's unique needs. An array of clinical, educational, and social services are provided to the children and their families by specially trained teams of educators and clinicians. In areas with large minority populations, bi-lingual providers are part of this team.

Project Hope funds will not be used to develop new Day Treatment services, as the youth will have access to the network of services already established statewide. Access to these services will be facilitated and coordinated by the case review team and case managers.

Wraparound/Recreational

Each local site receives funds to support the wraparound process. Funds are used to access a wide range of services, including, but not limited to, recreation, family outing, club memberships, attendance at local sporting events, art lessons, music lessons and horseback riding lessons. This is a flexible pool of money which is used to fill in the

service gaps, not funded by traditional funding sources. All 8 sites will receive additional wraparound funds for Project Hope participants.

Therapeutic Foster Care
Therapeutic Foster Care services have been established with Project REACH RI funds, these services are core components of the system of care and will be available for Project Hope participants.

Transition Services
All case review team members will receive training on transition services and writing transition plans, including transition from child to adult mental health system and transition into adult competency.

Inpatient Services
Rhode Island has two outstanding psychiatric hospitals providing inpatient mental health services to children and adolescents: Butler Hospital and Bradley Hospital. Staff at both hospitals have been involved in the state's system of care activities and provide ready access to inpatient services, when needed.

Advocacy
Advocacy is provided by the Family Service Coordinators, whose primary function is to advocate for the youth and family, and to assure they have access to all entitlements. Additional specially trained Family Service Coordinators from minority populations will be hired for Project Hope.

Non-traditional Mental Health and Other Support Services
The local system of care structure and the case review process upon which Project Hope is being built, has established a very viable mechanism to access non-traditional mental health and other support services. This process will be used for Project Hope participants assuring coordination of these services through the Individual Service Plan (ISP). This has been done very successfully with REACH RI; even greater emphasis will be placed on accessing non-traditional resources in Project Hope.

III. EVALUATION SUPPORT PLAN

For the past eight years, the Rhode Island Department of Children, Youth and Families has collaborated with The Consultation Center of Yale University School of Medicine to evaluate the system of care for children's mental health. Dr. Joy S. Kaufman and Dr. Jacob Kraemer Tebes have agreed to serve as the Evaluation Consultants for this system of care development and evaluation. Upon receipt of this award the contract for this evaluation will be formalized.

A. Development of Evaluation Instruments
During the initial year of Project Hope, the evaluation team will meet with a task force of key stakeholders (including the project director, parents of youth and youth involved in

the system of care, and representatives from participating agencies) to identify outcome indicators and to develop and/or modify the necessary forms and processes. As was done with the Project REACH RI Evaluation, the Evaluation Consultants will work with this task force to weave together the data elements required by the national evaluation team with those identified by the local sites. In addition, the Evaluation Team will rely on the expertise of the task force to develop procedures that are inclusive of all members of the identified population. The end product will represent the needs of both the local and national community in demonstrating the effectiveness of this program. After the development of the evaluation instruments and processes, the Evaluation Consultants will hold Statewide trainings to share the evaluation materials and to obtain feedback. The goal is to institutionalize the evaluation by using these forms. All evaluation materials will be translated into Spanish, Portuguese, and Creole as these are the primary languages spoken in the State after English. In addition, translators will be available to work with families who speak other languages. Project REACH RI/DCYF has developed translation services available in a planned or emergency basis in 40 different languages and American Sign Language.

B. Consent to Participate in the Evaluation

Since descriptive data will be collected from all youth and families involved in the system of care, all families will be introduced to the evaluation during their initial meeting with the Family Service Coordinator. Families will be asked to sign a Release of Information form. This Release of Information form will indicate that descriptive, risk, and service utilization information will be shared with the local and national evaluation teams, but that all identifying information will be removed before this information is given to an evaluator (see Appendix IX). Families will be asked to sign two copies of the form (in their primary language) and will retain one copy of the form. Project REACH RI indicates that this process works, as only 2 out of more than 1000 families approached declined to sign this Release of Information. Families are provided with a toll free phone number (1-800-TCC-0502) if they have any questions, concerns, or feedback.

After participation in the Multi-Agency Case Review meeting each family will be approached and a member of the evaluation team will explain that, along with collecting descriptive and service utilization information from all families, we are asking 250-300 families to meet with us to help us more fully evaluate how successful the system of care is in working with families. If the family is interested in participating in this outcome evaluation process they will meet with a member of the evaluation teams and participate in a Consent Interview where the process will be explained to them in depth including benefits and anticipated risks from participating in the evaluation (see Appendix IX). We anticipate enrolling 95 families in the first year, 95 in the second year, and 65 families in the third year of the grant.

C. Data Collection

Our experience with Project REACH RI has taught us that utilizing trained research interviewers to meet with family members in their home works best to insure complete data that is comparable across the different waves of data collection. We plan to use evaluation strategy developed for Project REACH RI as a model for this evaluation.

Currently, each of the 8 LCCs employs a .5 FTE On-Site Coordinator. This person was responsible for conducting the Consent Interviews for each of the families enrolled in the Project REACH RI evaluation and is currently the person responsible for tracking the families in the REACH RI evaluation in their area. Since we are at the point of conducting once yearly follow-ups of the 501 families in the REACH RI evaluation there is time available for each On-Site Coordinator to serve a similar role in the Project Hope evaluation. We anticipate that the Providence and Pawtucket/Central Falls On-Site Coordinator position will have to be enhanced to a 1.0 FTE as the majority of youth at the Training School are from these areas.

In addition, The Consultation Center employs 10 per diem Research Interviewers who conduct the semi-structured interviews in the families' homes. Currently we have the capacity to interview families in English, Spanish, Portuguese, and Creole. *In addition, 40% of our interviewers have been parents/caregivers of children enrolled in the system of care*. Our plan is to utilize some of the current pool of interviewers and to hire additional interviewers for this new project with an emphasis on employing family members and caregivers of youth enrolled in the system of care. The Research Interviewers are typically assigned to two or three geographic areas and work closely with the On-Site Coordinator to enable continued family involvement in the Outcome Evaluation. The Research Interviewers read all of the questions to the parent/caregiver to enable those who are not literate to fully participate in the evaluation without disclosing that they may have a limited educational background.

Once the interview is completed, the Research Interviewer will return the interview materials to the On-Site Coordinator who will insure that all identifying information is removed; then a Xerox copy is forwarded to The Consultation Center. The original is maintained for files at the local site.

D. Tracking

Our experience with Project REACH RI has indicated that maintaining a Statewide Tracking Data base is essential in retaining families in the Outcome Study as families move quite frequently within the State. The Consultation Center developed and maintains the Tracking Data Base for Project REACH RI and will provide the same role for Project Hope. Currently, we have a better than 95% retention rate in the REACH RI evaluation with more than 450 six-month interviews completed; 325 twelve-month interviews completed; 24-month data collection has just begun, with three completed interviews.

Currently, On-Site Coordinators receive a list every two weeks of which interviews are due in their area. The On-Site Coordinators then assign interviews to an appropriate Research Interviewer insuring that the linguistic needs of the family are being met. The Research Interviewers then have two-weeks in which to complete the interview. If the family is not available at the phone number or address given, the On-Site Coordinator has contact information provided by the family to help in locating them.

E. Compensating Families

Twice a month The Consultation Center issues stipend checks to family members to pay them for participating in the Outcome Evaluation. Families will be paid $20 for each completed interview. The family is sent a self-addressed stamped postcard with the stipend, asking them to evaluate their experience with the interview and interviewer to insure that the experience was comfortable and they felt respected in the process.

F. Utilization and Cost Data

Evaluation staff will work with all partner agencies to obtain utilization data from their MIS systems and cost data. These data will be transformed into the structure established by the national evaluators and transmitted to them.

G. Entry, Cleaning, and Transmission of Data to National Evaluators

The Consultation Center will maintain responsibility for entry, cleaning, and transmission of data to the National Evaluators. In addition, the Evaluation Team will provide monthly, quarterly, and annual reporting to the Project Director and the community to insure full dissemination of the evaluation data.

IV. PROJECT MANAGEMENT PLAN

The Rhode Island Department of Children, Youth and Families (DCYF), the lead agency for this grant, is a consolidated child and family serving state agency providing Child Welfare, Children's Behavioral Health (formerly Children's Mental Health), and Juvenile Corrections services (organization chart, Appendix VII). The Director of DCYF, Jay G. Lindgren, Jr., is a nationally recognized authority on juvenile justice with a strong commitment to developing an integrated, statewide community-based system of care. Mr. Lindgren recently established the Division of Children's Behavioral Health, elevating the status of children's mental health services from a unit to a major division within the Department.

The Principle Investigator for Project Hope will be the Chief of Children's Behavioral Health, Kathryn Nicodemus, LICSW, who has over twenty-five years experience in Child Welfare, Children's Behavioral Health, and Juvenile Corrections. Ms. Nicodemus currently is the Principle Investigator for Project REACH RI and has expertise in all facets of community-based system planning and implementation.

The Project Director will be Susan M. Bowler, Ph.D., the present Director of Project REACH RI. In addition to her experience as Director of Project REACH RI, Dr. Bowler has extensive experience working in the state's Juvenile Corrections system, in the State Legislature, and in the area of Substance Abuse. Dr. Bowler, a family member of person with a serious emotional disturbance, has taken a leadership role in developing progressive child and family policy affecting youth and their families who are involved with the state's Juvenile Corrections system.

A full time CASSP Coordinator (MSW) will be hired as Dr. Bowler's assistant. Every effort will be made to hire a family member, who has had experience with the state's mental health system.

The Project Secretary will be, Pamela McCalligett. Ms. McCalligett has been working as the secretary for Project REACH RI, and is an invaluable resource to the Project team.

DCYF will fund 3 MSW staff who will be liaisons to the local sites. Each liaison serves in this capacity for Project REACH RI and has vast experience in local system planning and implementation. DCYF will provide all office space, materials, phones, mailing costs, and computers as in-kind support. The Project Hope office, within the Division of Children's Behavioral Health will be in the DCYF Administration Building.

Under Project REACH RI, the 8 local sites have had the autonomy to determine their own organizational structure; this will continue for Project Hope. Each LCC selects an LCC Chair person who coordinates local activities. The LCC also identifies a fiscal agent and develops its own governance protocols; information is freely shared across sites at monthly Advisory Committee meetings. LCC paid staff includes LCC Coordinators, Family Service Coordinators, and Site Coordinators (for enrolling families). LCCs will receive additional funding to support enhanced local activities included in this initiative. LCC leadership is an in-kind community contribution.

Organizational Charts, a Year 1 Time Line/Management Chart and a State map showing the mental health catchment areas are included in Appendix VII. Project Hope will be at full implementation in Year 2, and all the first Year activities will continue to support the system of care. In Year 3, a Managed Care pilot project will be started under the direction of Kathryn B. Nicodemus, the Chief of Children's Behavioral Health.