



Mid-Valley Behavioral Care Network

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February 25, 2010

Ms. Toni Peterson, Special Projects Manager
Mr. Bill Bouska, Child and Adolescent Mental Health Services Manager
Oregon Department of Human Services
500 Summer Street NE
Salem, Oregon 97301

Dear Toni and Bill:

We want to thank you for the impetus to prepare this proposal. Over 168 people and organizations contributed many hundreds of hours collectively to plan and write the attached proposal. The regional Project Planning Team (see Attachment A) met every Friday afternoon at the Marion Child Welfare office throughout January and February to develop the material for the Letter of Intent and the Readiness proposal. The intensity and depth of these conversations have already changed our relationships and how we will be working together in the future.

- Our vision is shared and clear: we want children and youth to have connections to people who love them, skills to succeed with each life task, and hope for the future.
- We had confidence in the value of youth and family direction; now we have a detailed plan for realizing this value throughout our activities.
- We have clarified our intentions regarding cultural competence and the steps for improvement.
- After spending many hours together, local system of care partners now identify with regional efforts and success.

Parallel to our vision for youth, the system of care partners in the MVBCN region now have deeper connections, clear plans for system development and great hopes that we will be selected as a demonstration site for the Statewide Children's Wraparound Initiative. Thank you for consideration of this proposal. If I can assist with any further information, or answer any questions, please feel free to contact me.

Sincerely,

Jim Russell
Executive Manager, MVBCN

Mid-Valley WRAP's Response to Readiness Criteria

Statewide Children's Wraparound Initiative

Mid-Valley WRAP is ready now to be a pilot site and work with state and local leadership and other pilot sites to move the System of Care forward. Our community's vision is a responsive, coordinated, and culturally competent, continuum of care that builds on each child's strengths and meets the needs of children so they have meaningful connections, life skills and hope for the future.

We are ready:

- With a track record of listening to children, youth, parents, foster parents and providers to identify strengths and needs leading to services, supports, and policy changes that will prevent further disruptions and create stability in children's lives
- With the administrative services organizational experience and expertise provided by the Mid Valley Behavioral Care Network (MVBCN)
- With a demonstrated commitment, experience and infrastructure to support High Fidelity Wraparound
- With key leadership who have system of care development experience
- With the support of our system of care partners and long-standing collaborations to develop innovative services and coordinate care for children served across our agencies
- To build on our Child Welfare and mental health partnerships in co-location of staff, work flow coordination, and integration of service planning
- With a culture of inclusiveness, trust in the group process, and shared decision making
- To build on our community support for foster care and local partnering with business leaders, neighborhoods, and churches
- With cultural responsiveness in working with our diverse communities
- With a sound foundation in evidence-based practice support and ongoing workforce development

Our proposal is a group effort that reflects our value of inclusiveness. We listen to the youth, parents, foster parents, allied agencies and the providers in developing our proposal. Please see Attachment A for a list of the Project Planning Team who together have developed this proposal and Attachments B, C, D, E and F for focus group information gathered from youth, parents and providers. Please see Attachment G for declarations of support and commitments to work with MV-WRAP. We are ready, as is the State of Oregon, to vigorously move this vision forward.

I. Awareness of System of Care Values and the Wraparound Process

I.1 *Demonstrate a working understanding of System of Care values and principles (see Summary of System of Care Values document).*

Family Driven and Youth/Young Adult Guided System

True empowerment means decisions are made by those most impacted by them. Mid Valley Behavioral Care Network (MVBCN) developed out of a shared belief that through an inclusive collaborative process, solutions are found that work for everyone. Out of this belief a strong value emerged of meaningful consumer voice at both the policy and program development level.

This culture of “nothing about me without me” and the inclusion of all stakeholders at the table were further reinforced in MVBCN’s implementation of the Children’s System Change Initiative. Youth and family advocates compose over 51% of the membership of the Regional Partners Executive Committee for Children and Youth. They actively participate on the Committee and its workgroups and have a high degree of influence. Family and youth advocates, providers, community partners and other stakeholders analyze and research the issues. Together they recommend actions that improve the quality of services and supports for children and their families. Policy and program committees across MVBCN programs strive to create an atmosphere where diverse ideas and honest input is encouraged and valued from all involved parties. MVBCN family, youth, and young adult (family/youth) advocates meet regularly as sub-committees of the Regional Partners Executive Committee.

The MVBCN’s commitment to family driven and youth guided care is further demonstrated by the “*Wisdom from Parent’s of Our Most Challenging Children*” presentation, the “*Take Charge*” regional trainings, and the emerging “*Western Region Youth Group*”.

In 2008, family advocates developed a presentation using a logic model with their personal stories to describe their experiences as they searched for help for their children. The presentation demonstrates what increases family resilience, strength, and improved outcomes for children. Based on survey results from the 2009 Building on Family Strengths Conference sponsored by Portland State University, “*Wisdom from Parents*” was very well received. This presentation is currently used to increase

LIVING VALUES

As a manager at the inception of the CSCI, I included families because it was on the list of things to do. Now, I cannot imagine adequately planning without having family input at every step of the process. Parent advocates have lived this life; they keep professionals on track and true to the SOC values because they simply know.

For too many years professionals have devalued their voices. I remind myself constantly to LISTEN. Each time I find myself resisting the Family Voice, when I ask myself ‘why?’ I learn a lesson. The adage nothing about me without me is only of worth if I listen.

**Dawn Cottrell, Manager
Yamhill Co. Family and Youth Programs**

awareness among professionals across the system of care in the MVBCN region. Two “*Take Charge for the Future*” trainings were sponsored in 2008 by MVBCN. These trainings were offered to staff from all youth serving agencies throughout the five MVBCN counties. Staffs were trained in a research-based curriculum. The curriculum teaches the skill sets needed to empower youth with developmental disabilities and mental health needs to facilitate their Child & Family Team meetings.

In November 2009, three youth and young adult advocates (youth) from the Regional Partners Executive Committee, supported by *Youth MOVE Oregon*, conducted a focus group (*Youth MOVE: Motivating Others through Voices of Experience*). Participants in the focus group were between 14 and 22 years old. These youth came together to share their experiences with the mental health system and make recommendations for change. As a result, a *Western Region Youth Group* is being developed through a MVBCN contract with Oregon Family Support Network (OFSN). OFSN will provide the education, coaching, and ongoing peer support for the participants. This group will draw from their experiences and perceptions of youth-serving agencies to give policy advice on relevant committees. These youth will lead the way for youth guided system change. In addition, the youth will work on self-directed special projects as requested by the Regional Partners Executive Committee and the MV–WRAP Advisory Council.

High Fidelity Wraparound Model

Over the past five years, MVBCN has developed a sustainable system for meeting the needs of children with the highest mental health needs named “New Solutions”. MVBCN uses a high fidelity wraparound model, which uses natural supports and system of care providers to meet the needs of children and addresses the family’s unique culture and priorities. Supports are built around the unique strengths and needs of the child and family.

The high fidelity wraparound model is:

- Defined by 10 wraparound principles that describe how the process is implemented
- Accomplished as designed by the National Wraparound Initiative in four phases
- Each phase has related activities that describe what is to be done
- Includes Family Support Partners as key members of Child and Family Teams (CFTs), thus supporting family driven and youth guided care
- Fits the four components of the theory of change

MVBCN has a working infrastructure in place to expand high fidelity wraparound to another population. This structure was built and supported through three years of performance based training and coaching by Vroon VanDenBerg. In a committed effort to prevent model drift, MVBCN monitors ongoing fidelity three ways using:

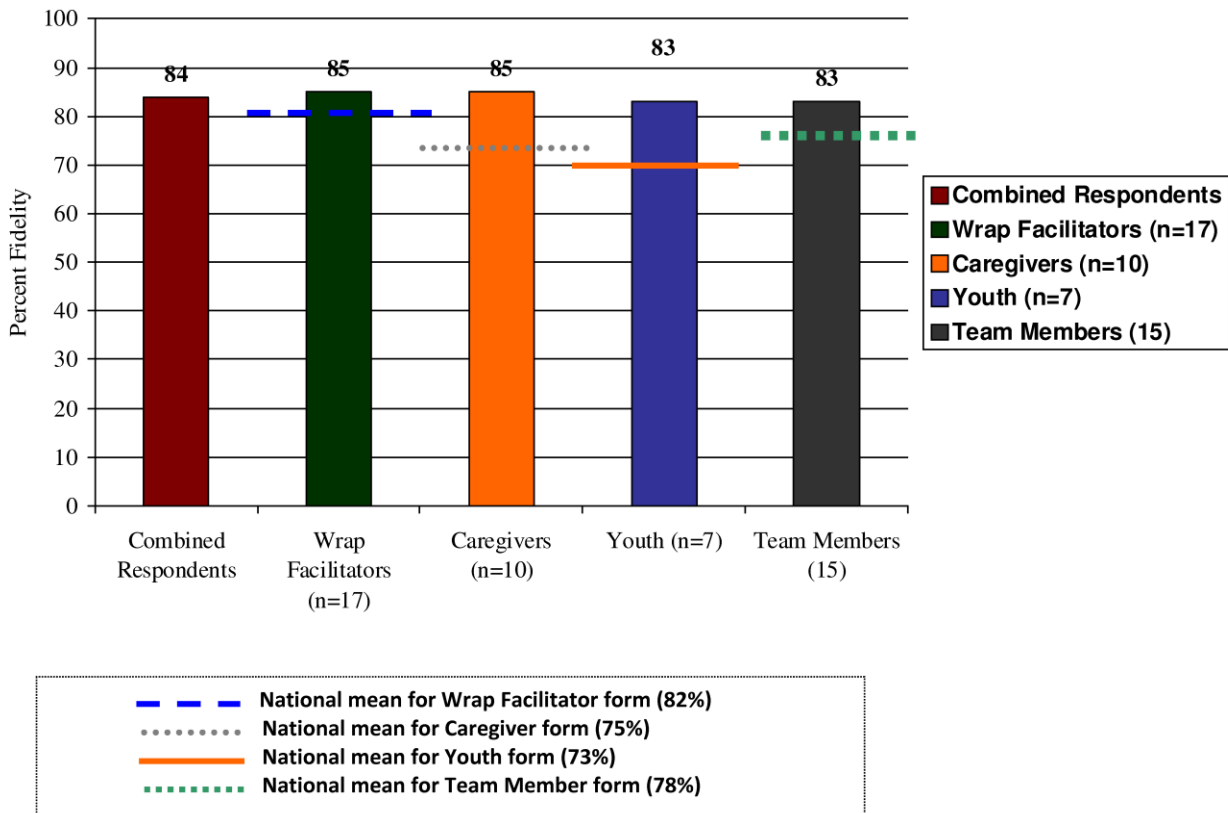
- Wraparound Fidelity Index (WFI)
- Fidelity Review
- Infrastructure Survey

Wraparound Fidelity Index

The WFI is an outcome tool used once a year to determine the extent to which the services and supports adhere to the principles and primary activities of the wraparound service coordination process. The WFI consists of 10-20 minute telephone interviews with the parent/caregiver and youth (if 11 or older), the Wrap Facilitator and another CFT member. The main objective of WFI is to provide feedback to staff, supervisors, and coaches on the level of fidelity for individual Wrap Facilitators. The WFI also helps agencies to promote targeted training and support. In the *Wraparound Fidelity Index version 4.0 Summary Report* for 2009, conducted by the Wraparound Evaluation and Research Team of the University of Washington, MVBCN scored above the national mean on fidelity standards on all ten principles and four phases of wraparound. See Attachment H for full report.

The graph below shows MVBCN's total wraparound fidelity scores, expressed as a percent for each of the respondents. These scores reflect broad summaries of all the collected interview ratings and are useful when one is interested in assessing overall fidelity.

Percent Wraparound Fidelity for Combined and Individual Respondents



Comments from 2009 Wraparound Fidelity Index

Caregiver/parent

- Flexibility of process has been valuable. We may not be a "typical" wraparound family, but the process has been able to help us meet our needs; and very helpful with situational problems.
- Facilitator has been especially great in celebrating successes and accomplishments.
- It's helpful to have a large team with people of different backgrounds and different points of view.
- Pivotal thing has been having goals, reviewing them at 6-month point; helped to see progress we have made.
- Wrap gives everyone a chance to communicate. Helped our child advocate for herself.

Youth

- Facilitator has done so well; if it weren't for her, I think I would be in jail now.
- Enjoy the effort everyone puts in.
- It's great.

Team Member

- Has given mom strength to ask for help from friends and family. Every piece of child's world is represented on the team. It is a gift for him to have team in place, allows him to be a child.
- Strong team, family has had a positive response to wraparound.
- All voices are heard.
- Client has come a long way, made a complete turnaround.

Fidelity Review Process

Every six months the Wraparound Coach completes a fidelity review of three clinical charts for every credentialed Wrap Facilitator. The review also uses live observation of team meetings (scored to high fidelity standards) to provide an overall summary of the facilitator's and program's strengths and needs. In addition, the fidelity review includes progress on items identified by the Regional Partners Executive Committee's Quality Improvement Plan. The review focuses on areas indicated in the previous year's WFI that need improvement. In 2009, the following outcomes were identified:

1. Increase youth participation on CFT meetings measured by progress note documentation
2. Increase in percentage of natural supports on team, measured by supports listed on wrap plan
3. Transition addressed in meetings and on wrap plan—documented in progress notes and wrap plan

Fidelity scores and county work plans to address program needs are reported to regional leadership through quarterly MVBCN Quality Improvement Plan reports.

Infrastructure Survey

Since 2006, the five MVBCN region Community Care Coordination Committees (CCCCs) have been assessing their system support for wraparound using components from the *Community Supports for Wraparound Inventory* (Walker, Bruns, & Penn, 2008). This Infrastructure Survey provides expectations for ongoing community and collaborative support for the wraparound process. The Infrastructure Survey is a reliable and valid mechanism for measuring levels of system of care implementation. Survey results are used to develop recommendations for CCCCs to improve their fidelity. The 2008 MVBCN Infrastructure Survey recommendations are reviewed at MVBCN Regional Partners Executive Committee. See Attachment I.

In summary, MVBCN will build on its existing service system that delivers high fidelity wraparound to children and families. Research demonstrates that high fidelity wraparound produces improved outcomes, compared to traditional approaches in the following areas:

- Increased permanency and stability for children
- Decreased restrictiveness of residential environments
- Improved behavior and mental health symptoms
- Improved school and early care outcomes
- Decreased family and child safety issues and risk factors
- Increased family and child protective factors
- Increased family engagement and satisfaction with services
- Increased family resources to support their own children

-Vroon VanDenBerg.

1.2. Describe prior and current collaborative efforts by community partners to develop a local system of care based on these values, principles, and planning processes. Describe lessons learned if applicable. Describe how current efforts will be coordinated with Statewide Children's Wraparound Initiative.

The following are examples of prior and current collaborative efforts by community partners to develop a local system of care. We believe that this experience provides a solid foundation as we begin our work as a demonstration site and continue to build a system of care.

Regional Collaboration

The Mid-Valley Behavioral Care Network and the five counties that make up the region have been working for years towards the vision of a system of care. We believe we can build on existing positive relationships, partnerships and agreements during the Phase 1 demonstration. We enthusiastically embrace the values and principles of a system of care and the wraparound process. The primary partners in this phase, DHS Child

Welfare, MVBCN and the Community Mental Health Programs (CMHP), have existing agreements providing integrated work process and co-location of staff. Other System of Care partners in this region have a strong culture of collaboration. We also will build on the community and faith based initiatives in this area to support children in the foster care system.

MVBCN began addressing the complexities of system of care relationships in the roll out of the Children’s System Change Initiative. The MVBCN developed stakeholder workgroups/committees of family/youth advocates, Child Welfare, educators and day treatment providers. All groups prioritized roles, responsibilities, agency mandates, and cultures. The Regional Partners Executive Committee, which included system of care partners, developed policies to move the initiative forward. In addition, individual cases that resulted in line staff discontent were treated as learning opportunities to improve coordination between child-serving agencies. A series of retrospective case review meetings were convened to better understand partner decisions and improve the process for the future.

The MVBCN’s Regional Partners Executive Committee made the recommendation to MVBCN Council to commit resources to learning and sustaining high fidelity wraparound. High fidelity wraparound is a model that acknowledges the direct connection between the complexities of a child’s needs and individualized care that is strength based, culturally responsive and tailored to the individual needs and choices of the child and family. Furthermore the five counties have a strong commitment to sustain fidelity by implementing an outcome based quality system. The quality program uses research-based measurable indicators of success to monitor progress and development of staff and county work plans to meet fidelity standards. This focus on quality and outcomes demonstrates that our system holds itself accountable in a similar way to the CFTs that tie the goals and strategies of the integrated services plan to measurable outcomes and monitors and revises the plan as needed.

All five MVBCN counties system of care stakeholders provided input to develop a rich menu of community based services (e.g., skill trainers, mentors, respite homes, treatment foster care) and family support programs. This array of services and supports were designed to enhance the strengths of the child/family through natural supports, community activities and enrichment activities, and to serve youth in the least restrictive setting.

The decision to apply to become a Pilot Demonstration Site for the Statewide Wraparound Initiative was initially a collaborative discussion at the county level with Child Welfare partners in District 3. This discussion quickly expanded to a region-

LIVING VALUES

As we continue to provide our support and encouragement to foster care children, we realize each child is unique with background, strengths and weaknesses that require individualized care and attention in order for them to grow into healthy and productive adults. The MV-WRAP initiative recognizes these needs and will promote positive programs and supports while creating an environment for innovation and cooperation among a wide variety of stakeholders working together for the sake of our children.

Larry Murrell
Pastor, Christian Center of Salem

wide interest amongst community mental health programs and DHS partners in Districts 1 and 4. A project-planning group was developed and met weekly to discuss the vision and design of Mid Valley WRAP. Project team members conducted focus groups and meetings with youth, families, foster families, system of care partners, allied agencies and BRS/Mental Health providers to help define the needs of the cohort population and create a system that better met their needs. All involved committed to participating in cross training activities. This is an ongoing effort to educate one another on agency programs and share our areas of expertise with children and families.

MV-WRAP is unconditionally committed to integration of services for children with complex needs and their families using the system of care core values and the 10 principles that provide the framework for the wraparound process.

Collaboration with Family Advocacy Groups

Oregon Family Support Network (OFSN): MVBCN has contracted with OFSN for more than three years to provide consultation and support for the development of a sustainable network of family support activities, peer to peer training and natural support enhancement. This contract has provided:

- Support and training for Family Support Partners.
- Family workshops delivered using parent advocates in a peer to peer model.
- A cadre of trained parent advocates who provide workshops, facilitate support groups and Collaborative Problem Solving Book Clubs in all five counties.
- The design of a strategy in the early stages of implementation to increase long lasting natural support systems for children with significant mental health needs.
- Health/wellness fairs, opportunities to enhance connections through camping trips, potlucks family night games and crafts, etc.

Collaborations across Counties

Early Assessment and Support Team (EAST): MVBCN brought EAST to the State of Oregon. This approach has had such good outcomes in working with early psychosis that the State has funded its growth statewide.

Youth Services Teams (YSTs): Since 1978 these teams included the system of care partners: DHS-Child Welfare, Schools, Mental Health, Juvenile Department, and Alcohol and Drug treatment on interagency teams in middle and high schools throughout the five counties.

Interagency Response to School Tragedies: As a further development of the YSTs, schools and county mental health developed a suicide risk assessment and intervention program, sometimes called Flight Team. YSTs also developed a Threat Assessment Team, which includes a protocol for levels of response to threats of violence. The Threat Assessment Teams have a case staffing process to evaluate risk and formulate an interagency intervention plan.

Community Integrated Support for Children in Oregon (CISCO) Project: The CISCO Project was a pilot between the MVBCN, the five CMHPs and Trillium Family Services. It focused on reducing stays in psychiatric residential care, the development of individualized community-based supports for each child, and coordination of care across the system.

Safe Schools/Healthy Students Federal Grant: Both Linn and Marion Counties received these grants that allowed systems of care to develop. These partnerships included schools, juvenile justice, law enforcement and the mental health crisis program. They provided integrated service teams, school-based prevention, crisis and treatment services, violence prevention, family intervention, and care coordination by Family Support (not a peer) positions.

Intensive Treatment and Recovery Services (ITRS): County Alcohol and Drug providers have partnered with DHS to provide effective treatment for parents with alcohol and drug issues that have contributed to their children being taken into custody.

Youth and Family Workgroup: The Program Supervisors of public mental health providers in the five-county region have met monthly for over 15 years to support each other in implementing best practices and developing an array of services that meet the needs of children, youth and families.

Transitioning Out of Foster Care: Marion, Polk and Yamhill Counties currently collaborate on a “Transitioning out of Foster Care” Work Group, whose aim is to improve transition services for teens as they leave the state system.

Memo of Understanding (MOU) regarding Children transitioning to local schools from residential programs. Facilitated by Willamette Education Services District (WESD), the systems of care partner agencies developed a MOU that describes expectations for information sharing as children transition from residential care or are placed in foster care outside of their community. A common form was developed for sharing information on needs and supports to successfully integrate the child into the local school and community.

The Fostering Hope Initiative: This partnership of 25 agencies in Marion and Yamhill Counties under the leadership of Catholic Community Services has a shared purpose to build a neighborhood based system of care, involving our agency partners and local neighbors, strong enough to reduce the need for foster care 50% by 2020. Decision makers, resource representatives, youth and family members have met twice each a month for over a year to define the purpose, values, strategies, and implementation plan for Fostering Hope. Funding for Fostering Hope is coming from a

LIVING VALUES

The New Solutions Wraparound Program has been a huge gift for our family in so many ways. It has helped us to find resources to not only help parent a challenging child, but also avenues for my children to learn new behaviors and grow into successful young people.

Before coming to the program our life was mayhem. Now we like to be around each other—most of the time.

**New Solutions Parent,
Yamhill County**

rich partnership of service providers, foundations, and community business leaders. The Fostering Hope Initiative has just received a Meyer Memorial Trust grant award of \$200,000 to begin services.

Head Start Mental Health Consultations: Marion and Yamhill Counties have embedded mental health staff at Head Start programs, using the principles of the Starting Early/Starting Smart evidence-based practice (EBP).

Youth Gambling Abuse: Confederated Tribes of Grand Ronde is working with Polk and Yamhill County Mental Health combining efforts to address gambling abuse.

School Based Health Clinics: There are two Health Clinics in Yamhill County and one at Hoover Elementary School in Marion County. The clinics include mental health and public health staff on-site weekly for information, referral and consultation.

Collaborations within our Counties

Linn County Council: Linn County has a history of exceptional collaboration. In 1985, key community and school partners formed the Linn County Council for Integrated Child and Family Services (Linn Council). Its role is to sustain support to the YSTs and to local school and community collaboration. With a strong commitment for data driven strategic planning, the Linn Council uses evidence-based solutions to meet identified needs. Council Members include Linn County Mental Health, seven school districts, Linn County Alcohol & Drug Program, Sheriff's Office, Community Services Consortium, DHS, Education Service District and the Juvenile Department. The Linn Council developed a white paper on social service supports and improvements needed for children and families. They then presented this collectively to the Oregon Legislature.

Linn County Mental Health/Child Welfare Co-location and Trauma work: Mental health staff are located at the Child Welfare offices to provide mental health assessments, training and consultation on trauma and treatment interventions.

Linn County adapted the evidence-based Trauma Focused-Cognitive Behavioral Therapy intervention to train parents, foster parents, CASAs and caseworkers. The region has adopted this intervention.

Teen Parent Consortium: This consortium was a multi-agency effort that responded to the high rates of teen pregnancy in Marion County. Over a few years time, focused efforts with youth and the communities resulted in a significant decrease in these rates.

Marion DHS-Child Welfare "Well Being Team": Child Welfare and the Marion County Health Department's Community and Providers' Services (CAPS) have developed an MOU to ensure that children entering foster care receive mental health assessments. An early mental health assessment ensures timely and effective referrals

for mental health care. The Marion Branch has formed a Well Being Team that ensures that medical, mental health and dental evaluations are accomplished in the first 60 days after a child enters foster care. Mental Health provides on-site mental health assessments and Child and Adolescent Needs and Strengths (CANS) screenings. The Well Being Team and CAPS mental health professionals are co-located and continually review work processes for effectiveness, timeliness and customer service. The Well Being Team manages the logistics of scheduling interviews with the child, parent(s) if appropriate, foster parents and observations of parent/child interactions during scheduled visitation. After the assessment is completed, the mental health staff provides consultation regarding service planning and mental health services. With 8 outpatient agencies providing OHP services, the mental health consultation ensures better treatment. Children who are identified as having significant mental health issues are then given a Level of Need Determination (LOND) using either the Child and Adolescent Services Intensity Instrument (CASII) or the Early Childhood Services Intensity Instrument (ECSII). The mental health professionals providing the assessments are same New Solutions staff who provide the LOND. Access to higher levels of services and supports through the New Solutions wraparound process is expedited.

OYA/Juvenile/Mental Health/Alcohol/Drug partnership for screening and referral: A Change Team in Marion County implemented a nationally normed computer based screening, the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2), for youth on probation or placed in detention. Cross training in the referral system improved interventions for youth.

Marion County’s Latino Team: In 2009, Marion County Health Department Children’s Behavioral Health developed a Latino Team located in the Health Department’s Woodburn offices. The Latino Team provides culturally responsive services that address barriers to receiving mental health services. Services include parenting supports, community outreach by promotores, counseling, skills training and medication management.

The Latino Team uses the evidence based practice “Starting Early, Starting Smart” by embedding mental health services in non-clinical settings such as schools. The Latino Team uses a relationship-based approach to connect with clients instead of the traditional method of relying on clients calling an anonymous receptionist at a mental health clinic. The Latino Team partners with Salud Medical Center, Migrant Head Start, Migrant Farming Housing, Oregon Child Development Coalition, Pineros y Campesinos Unidos del Noroeste or Northwest Tree planters and Farm Workers

LIVING VALUES

I believe we can learn so much by listening closely to the stories told to us by our children. Frequently, those stories describe fantastic times and fun experiences, while others detail lonely and scary events, often including neglect and abuse. We can certainly revel in the positives. However, we cannot ignore a child’s plea for help and support, especially coming from some of our most vulnerable children—those in foster care.

There are many, many dedicated people throughout our extended community that are constantly pushing the envelope in support of our foster care kids in search of comprehensive program and service delivery for all of the right reasons. In the end, in order to be really successful, we all need to be working together on behalf of these children.

**Janet Taylor
Mayor, City of Salem**

United. This results in an increase in natural supports and the community connecting to Latino services. The Latino team has become a trusted member of the community.

Foster Care Action Team: Marion County Casey Family pilot site evolved out of a Foster Care Action Team. This group of agency and business professionals works together on recognized issues within the foster care system. The team includes members from the DHS, Commission on Children and Families, District Attorney, Catholic Community Services, foster care providers, CASA, faith community, business owners, and other agency representatives.

The identified goals of this team are:

- Safely reduce the number of children in foster care,
- Increase relative placements for children,
- Reduce the number of children entering care,
- Increase foster care exits,
- Reduce the disproportionality of placements for Native and African American children,
- Maintain or reduce current child abuse/neglect reoccurrence rates,
- Increase the availability for quality foster homes and needed supports to foster parents.

Marion County System of Care Steering Committee: The system of care agencies identified in House Bill 2144 have met over the last two years to prepare our community to be a pilot site for Substance Abuse and Mental Health Services Administration (SAMHSA) System of Care grants and the Statewide Wraparound Initiative.

Great Beginnings: The early childhood providers in Marion County have met for over 20 years to develop an early childhood system in the county. With leadership from a local judge and the Children and Families Commission, this consortium has developed partnerships to support literacy, child care providers and services to foster healthy attachment.

Project Bond: A local Marion County judge developed a partnership with parent support agencies. Project Bond created incentives for parents to receive services instead of court sanctions for law violation where the child was an infant or toddler.

Integration with Primary Care: Marion County mental health assessments are sent to primary care physicians for foster care children with identified mental health issues. Mental health professionals are stationed in two large pediatric clinics in Salem.

Foster Parent Supports: The Marion County Children and Families Commission has had a focus on foster care supports over the last few years. Examples include Fostering Hope; Foster Parents Night Out; Business and Faith Community Support of Foster Care Recruitment

Faith Community Support for Foster Care: The Marion County faith community is working in partnership with child-serving agencies, schools, and civic organizations to support and sustain healthy communities. Churches as Neighborhood Centers (CaNS) reflects a vision that every neighborhood will have a local, family-strengthening center located in churches and other community facilities. Working together, these partners hope to make it possible for every child, teen and adult to have a safe and empowering place within walking distance.

Salem Leadership Foundation (SLF): SLF is a faith-based organization which partners with neighborhood associations and leaders to bring people of faith and good will to work together on behalf of neighborhood schools and the community to support families within their neighborhood. SLF has amassed an enormous network of human resource capital and funds from grants and contributions to coordinate and help build positive community attributes. SLF builds bridges among stakeholders: people, churches, schools, agencies, cultures, business, non-profits, and neighborhoods. Over the years, Catholic Community Services (CCS) has worked cooperatively with SLF on many collaborative projects to strengthen families and neighborhoods including co-sponsoring a “Future Search” in the Grant and Highland neighborhoods, which helped lead to today's community-wide emphasis on family support and foster care. SLF and CCS also cooperated to help resurrect the struggling Salem-Keizer Community Development Corporation, which today owns nearly \$4 million of affordable housing in high-needs neighborhoods. The North Neighborhoods (N2) Community Progress Team is further testament to the collaborative leadership of SLF and CCS.

Building Partnerships with the Business Community: Several key business leaders in Marion County are “leaning in,” and becoming active partners in helping develop resources for families and neighborhoods. Many of our business partners have stated that they realize it is also their responsibility to strengthen families and not just rely on government to do the job. These leaders have often given direct monetary contributions to support the foster care system.

Family Lifelines: CCS is currently in year 2 of this three-year \$1,400,000 grant from the Robert Wood Johnson Foundation (RWJF) Local Funding Partnerships Program to build a community-based positive behavior support system. Initiating the project required the collaborative funding of RWJF, the Meyer Memorial Trust, United Way, Catholic Charities, and local donations. The original design for the project was developed over several months by a team of community members, including DHS, MVBCN, Willamette Education Services District, and CCS. Family Lifelines now provides a behavioral support team that includes a child psychiatrist, behavior support specialist, family consultants, mentors, planned respite and crisis respite. Family Lifelines assures that every aspect of the intervention is thoroughly grounded in the child and family's needs. These services help meet the needs identified in the Strengths/Needs/Culture Discovery and the Plan of Care.

Community Homes for Children: CCS has raised over \$3,000,000 dollars in cash and property to build Community Homes for Children in specific neighborhoods so that

youth in care can remain in the neighborhood where they were taken into protective custody. Foster parents move in to the children's home. CCS supports the foster parents and turnover rates are low, but if the foster parent decides to quit fostering they leave and the children stay in their home, neighborhood and school. Providing Community Homes also has eliminated the barrier of a physical structure for parents who are committed to fostering youth, but do not have the resources to maintain a home that meets licensing standards. The commitment is for the youth to have a home for as long as they need it.

In addition, a local philanthropist has committed \$120,000 a year to support services related to Community Homes for Children. The funding provides the flexibility CCS needs to support the youth in four homes. The donor simply wants youth supported in stable, nurturing homes and caring communities; as the base foundation for achieving positive developmental outcomes. This donor began his contributions in 1998 and has committed to continue funding "forever" through his family foundation. It costs CCS \$30,000 per year to run a home for five children, so as the number of Community Homes increases (currently there is property and funding for a total of 10 homes) CCS will need to find sustainable funding for the additional six homes. The Community Homes would be able to provide stable foster care homes for up to 30 Phase I children in the statewide Wraparound Initiative.

LIVING VALUES

I learned that a lot of my anger was around being alone—feeling all alone, recycling through foster homes alone.

Wraparound helped me stay in one place—one home—no matter how many upsets I had. New Solutions gave me a family.

Devin Raynor
Community Homes graduate

Future Search: CCS has concentrated its efforts in neighborhoods with high populations of generational poverty. They have co-sponsored Future Search conferences within the neighborhoods to answer the question, "How can we create conditions in this neighborhood that support parents, including foster parents, to raise children well"? The goal of each Future Search was to help a whole community see and develop their neighborhood as a great place to raise children and youth. This partnership believes that it is essential to develop systems of care for neighborhoods as well as youth and their families so that the area where a youth lives becomes an asset for families and children.

Hispanic Human Services Council: This multi-provider effort addresses barriers to access, supports needs and coordinates services to Hispanic families.

Transitional Aged Youth Housing: Working with Child Welfare, CCS's transitional housing program at Center Court Commons is a safe place to stay. The Center Court Commons assists with independent living skills and helps young adults be on their own.

Mission/Transition: Marion County Health Department has received a grant with a capacity of 30 for youth who have been in Child Welfare or OYA custody as they transition into adulthood. This program uses the High Fidelity Wraparound to develop

supports for the youth. Two Youth Support Partners engage the youth and support them as they navigate the challenges of transitioning into independent living. The youth are given skills training and learn to facilitate their own team.

Co-location of staff: Polk County system of care providers are located together. This presents many opportunities to coordinate care and mutually build a service integration system. Housed together are PCMH, Juvenile Department, Commission on Children and Families, Public Health, Youth Programs and the Service Integration Team. Managers of all the system of care agencies attend a monthly Service Integration Leadership Council meeting to develop a local system of care.

Polk County Community Mental Health Outreach Team: PCMH has contracts with county school districts that allow PCMH's Outreach Team to work closely with local schools. This partnership ensures that unduplicated and timely services are made available to youth and families. The mental health staff also participates in a substantial number of school-based community events, such as Falls City Family Fun Night, Willamina's Last Blast, the county-wide Teen Maze, and West Salem Resource Fair.

Sanction Court: Sanction Court in Polk County provides intervention for juveniles cited with first time legal issues, such as a minor in possession of alcohol. Youth are assessed and recommendations are made regarding appropriate education and/or treatment. This is one method used for early intervention of alcohol and other drug use/abuse.

Community Partner's Meeting: Polk County Community Partners Meeting (CPM) meets weekly to staff cases and brainstorm solutions. CPM also works cooperatively to keep families intact by meeting one-time financial needs, such as paying an overdue utility bill. CPM includes Child Welfare and DHS Self Sufficiency, schools, PCMH, Children and Families Commission and other interested agencies.

PCMH Integrated Teams: PCMH has integrated teams within its department including: Triage & Intake Services, Outreach Services (school-based mental health prevention and treatment), New Solutions, Developmental Disabilities Services, and outpatient addictions and mental health providing co-occurring disorders treatment.

Collaboration with the Confederated Tribes of Grande Ronde (CTGR): PCMH coordinates services with the tribe, while The CTGR provides services to the Native American population and is a valuable resource in the County. PCMH and CTGR collaborated on a grant several years ago.

Regional Interagency Teams: Established in three Tillamook County school districts, the teams were led by a Coordinator and moved the county towards a system of care. Agency clinicians participated in a supervision group targeting child and adolescent clinical issues. As a small rural county, Tillamook agencies regularly work together to coordinate services.

Casey Project: Tillamook County is a Casey Family pilot site. This grant is aimed at identifying disproportionality of foster care placements for ethnic minority children. The pilot has identified both African American and Native American children with over representation in foster care.

Yamhill County Filial Therapy Project: A mental health therapist co-facilitates a parent group with Child Welfare parent visitation supervisors who are learning Filial Therapy. The supervisors then provide Filial Therapy coaching during subsequent parent visitations. Child Welfare provided childcare during the training groups.

Yamhill County Sex Abuse Treatment Project: Partner agencies include DHS, Mental Health, Schools, Juvenile Department, Prevention Programs, Family Based Services/Family Sex Abuse Treatment Services and local Child Abuse Assessment Centers.

Suicide Prevention Projects: This project was started by an adult consumer of mental health services. This person advocated for coordinated efforts after three high school students died by suicide in Yamhill County. The Suicide Prevention Coalition continues today to develop prevent youth suicide. Survivor Groups are facilitated by the founding adult consumer advocate.

Rainbow Family Services Treatment Foster Care/Shelter Beds: This is community collaboration in Yamhill County for treatment foster care/shelter care beds for Child Welfare children and youth. Currently there are 4 beds for treatment foster care and 3.3 beds for DHS shelter care. Placement in these beds is an interagency decision of the CCCC.

Yamhill County System of Care Advisory Group (SOC): This partnership includes Juvenile Justice, OYA, Mental Health, Drug & Alcohol, Head Start, Self Sufficiency, Child Welfare, Schools, family advocates, and other local stakeholders with the goal of addressing the gaps in the system of care within Yamhill County. One outcome was agreement that the SOC would be used to staff families where system issues create conflicts amongst local agencies.

Mental Health Services Provided In Schools: Yamhill County is collaborating with Polk County and Willamina School District to place counseling staff from the two CMHPs in the school district to better serve OHP clients who would not be able to access services due to transportation barriers.

Yamhill County Advisory Youth Council for Suicide Prevention: This council of local area high school students advocated within their schools for suicide prevention efforts.

LIVING VALUES

As the wrap coach for the BCN, it's been amazing to support staff along their wrap credentialing journey. To see the light bulb go on, to see their growth & professional development as they walk the talk of a truly strength based, family guided process is great.

You can't do this kind of work on a daily basis, have these kinds of interactions with families, and not be a wrap believer.

**Cydney Nestor,
Regional Wraparound Coach**

Family Advocates Business Service Agreements: HIPAA confidentiality requirements are addressed in these agreements with the Yamhill County advocates who are standing advisory committee members.

Quality Improvement and Biennial Plans Input: Yamhill County sought local family advocates input from attendees of Collaborative Problem Solving Book Clubs and Weekly Support Group to develop Quality Improvement Plans and Biennial Planning for State.

Training Curriculum Partnership with OFSN: Yamhill County partnered with OFSN to develop training curriculum for training natural supports (including extended family members, neighbors, friends) to be a support to families who have children with high mental health needs.

NAMI Memo of Understanding: Yamhill County has a MOU with the local chapter of the National Alliance on Mental Illness (NAMI). Yamhill County has a Family Support Partner who sits on CFT, and this person is also a member of NAMI. NAMI volunteers trained in “Visions for Tomorrow” curriculum offer these classes periodically to parents and caregivers.

Grandparent Support Group: The community-based Yamhill County services are provided to the Confederated Tribes of Grande Ronde.

Collaborative Problem Solving collaborations: With Yamhill County’s Family and Youth Services, Sheridan and Newberg School Districts, and Yamhill County’s branch of the WESD are co-developing the Collaborative Problem Solving (CPS) approach in their schools.

Parent-Child Interaction Therapy (PCIT) Latino Outreach: Yamhill County has hired bilingual/bicultural staff and created a welcome center for Latino families.

Youth Transition Committee: A grandparent advocate who sits on the Yamhill County CCCC is heading up facilitation of the Youth Transition Committee. The Youth Transition Committee is charged with developing policy and protocols for teens transitioning to adult services in Yamhill County.

Lessons Learned From Our Collaborations

- Planning without parents and without schools is shortsighted; takes more time in the long run, and can be oppressive for families.
- Integrated services results in better outcomes.
- Holistic assessment of children and their families is useful to planning a full service array.
- The need for staffing "cases" without families present has reduced since CFTs are directly addressing the challenges for improvement of mental health

conditions. CFTs can directly reduce the child's need for changing placements. Staffings without parents are used only when service providers want to clean up communication patterns among themselves and don't want to do so with families present since this can cause families to be in the middle and take sides between providers; or in cases where the child may be in harm's way and safety planning is needed to ensure that child is not at imminent risk.

- Children with no viable family, who will be raised by State Child Welfare, may need long-term teams supporting them. Planning needs to include long-term sustainable options. There needs to be a rapid response when a youth's stability is upset.
- The “devil is in the details”. Mapping workflow with those who are providing the services is important. The processes need to be continually reviewed.
- Co-location of staff creates workflow efficiencies and good communication. This also makes finding creative solutions to problems easier.
- Service planning starts with good evaluations. All areas of a child’s life need to be addressed in service planning.
- Involving bio parents and foster parents in the assessment process leads to better evaluations, service planning and involvement in services.
- Trust the group process. Involve from the beginning of planning, staff that will provide the direct service. It may take a bit longer but the product is better.
- Focus on customer service, client needs and outcomes.
- Traditional clinic-based practices don’t work well with the Latino population. Use of outreach promotores, embedding mental health staff in “normalized settings” and a focused Latino team directly addresses barriers to service such as: stigma in receiving mental health services, disconnect in cultural expectations of professionals, traditional clinic hours of M-F, transportation , taking time off work; immigration concerns, language etc.
- The Latino population has many variations within it (regions, legal status, generations, and language).
- Decision makers need to attend policy committees/boards
- MOUs are important to establish roles and responsibilities and address confidentiality issues.
- Children need a permanent, safe home before sustainable healing and change can occur.
- Family/youth involvement improves outcomes at every level
- Starting with strengths even in a crisis builds hope and optimism for the future
- Cross training is a continuous process that requires collaborative development efforts and commitment to embed into existing staff training requirements. Cross training is well worth the time invested.

LIVING VALUES

When you do low fidelity wraparound, you end up buying a lot of services. When you do high fidelity wraparound, you help families create the life they want.

We learned this lesson the hard way—we paid for it!

Jim Russell
Executive Director
MVBCN

- Needs are not always met best with professional services; high fidelity wrap creates long term supports for our children and families
- Skills training is most beneficial when it is focused on the child's interests. It helps to overcome barriers to their participation when participating in normal community and school activities
- Neighborhoods and business leaders are willing to step up if they are asked to do so.

How current efforts will be coordinated with the State Wraparound Initiative

All of these partnerships help weave a system of care in our region. We have a history of collaborations with system of care stakeholders and relationships have been built over many years of working closely together. Our system of care stakeholders will participate in all aspects of the development of our system with the Phase 1 Cohort.

The agreements and working relationships developed in Phase 1 will inform and steer the implementation in later phases. The leadership in our demonstration site (OFSN, MVBCN, Child Welfare, CMHPs) are also leaders in many of the partnerships listed above. They will coordinate the project with the other collaborations as we design and implement our model.

We will build on the partnerships between Child Welfare and the mental health providers who will become the CMOs for MV-WRAP. We will expand our co-location of staff. We will build on the relationships and combined workflow that have been developed over time. Our vision is an interdisciplinary team of Child Welfare Caseworkers, CMO Care Coordinators, and peer support specialists who will

work side-by-side in providing case management, care coordination and facilitation of high fidelity wraparound for these high needs children. The staff dedicated by Child Welfare to obtain medical, developmental, mental health and dental evaluations for children entering foster care will share information with all the providers. This information will be used to develop service plans that address all significant needs for that child. We will use the assessments and recommendations of the mental health providers in the service planning process for all children entering foster care. When children need specialized services, we will use the staff providing Level of Need Determinations to review and provide referrals for MV-WRAP's Review Committee.

The relationships and trust already developed through these direct Child Welfare/Mental Health partnerships will provide a solid platform for the integrated teams that will be the professional infrastructure for MV-WRAP.

LIVING VALUES

When the community, businesses, and faith community support foster care, the state can do a much better job of its responsibility of caring for children.

Kathy Prouty
Assistant Administrator
District 3

The MV-WRAP direct liaison to the state will be the Children's Services Coordinator of the MVBCN. The Coordinator also is the primary leader of the regional New Solutions, our local Children's System Change Initiative program which uses the high fidelity wraparound infrastructure. This correspondence of duties will facilitate regional coordination with the Statewide Wraparound Initiative. The MVBCN; Child Welfare Districts 1, 3, and 4; the Community Mental Health Programs and the OFSN leadership have 3 members on the Children's Wraparound Initiative Advisory Committee. All of these entities are committed to working closely with the Children's Wraparound Initiative Advisory Committee, the Child Welfare Project Site Operations Group, and the AMH-CAF Site Leads. We will learn from the other demonstration sites and the Statewide Wraparound Initiative leadership, and inform them of our learning. We will work with them on shaping policy and advocating for system change where current policies create barriers to our common vision of an integrated system of care.

II. Resource Plan

Number to be served

The number to be served by MV-WRAP is dependent on the fund disbursement approach adopted by DHS for this Phase 1 Initiative. MV-WRAP is preparing to serve 180 children or youth each month. MV-WRAP planners anticipate that the majority of Phase 1 population will have a need for services and supports for an average of eighteen months. This means that participants entering MV-WRAP will continue through the entire contract year. There will be some turnover during the year. MV-WRAP planners estimate that over 200 different children and youth will be served over the first twelve-month period, with a larger number in subsequent years.

The DHS approach for disbursement of funds has primary influence on the numbers of children and youth who can be served. As described in Readiness Section IV.4, the care coordination staff for MV-WRAP will be a combination of current New Solutions Wraparound Facilitators transferred to the project and new hires.

Existing staff are fully trained and able to begin building a new caseload on July 1, 2010. These staff will begin engagement with a full caseload of fifteen MV-WRAP members by August 1.

New staff will require a month of training and observation of skilled coordinators before they would have sole responsibility for high fidelity wraparound coordination; it will take two months to begin engagement with a full caseload of fifteen MV-WRAP members. These start-up schedules suggest that MV-WRAP will average 60 cases for the July 1 – October 1 period, 120 from October 1 – January 1, 2011, and sustain 180 monthly from January 1, 2011 onward.

For MV-WRAP to be financially viable the DHS funding will need to be on a capacity basis, with a presumed total caseload and full payment beginning at the start of the contractual period. In the final negotiations DHS and MV-WRAP may agree on a retrospective adjustment for the January – June 2011 period to assure sufficient performance for

the funds received. To the extent that DHS would like to see the full number of children served earlier in the contract year, then some of the funding will need to be available prior to July 1 to hire and train new staff.

LIVING VALUES

I have been involved as a layperson in the solicitation of foster care parents, as well as being a member of the Marion County Children and Families Commission. You can include me as a supporter of the five county MV-WRAP initiative. What appeals to me as a business person are the economies of scale, which will be ferreted out in this pilot project.

**R.E. Withnell, Owner
Withnell Motor Company**

Resource Plan

Presuming 180 children and youth in MV-WRAP, and specifications from the DHS December 16, 2009 Fiscal Plan (\$500 / month care coordination and \$45 / month administration per service recipient; Federal Block Grant for infrastructure/flex funds \$30,000 offered per project) provides funding as follows:

\$1,080,000	Clinical services
\$97,200	Administration
<u>\$30,000</u>	Infrastructure/flex funds
\$1,207,200	Total

The Fiscal Plan presumes a caseload ratio of one care coordinator to fifteen service recipients. The experience of current care coordinators in New Solutions (MVBCN's response for Children's System Change Initiative) suggests that 1:15 is a maximum ratio; these wraparound experts would prefer a 1:12 ratio because the needs of children and youth who will qualify in Phase 1 are even greater than the New Solutions average. However for planning purposes a ratio of 1:15 will be presumed. This implies 12.0 FTE care coordinators for MV-WRAP at \$90,000 each.

The proposed \$90,000 per FTE will be sufficient for the CMO to pay for a staff person with a Bachelor's college degree and for the office and other expenses to conduct their work; it will not quite cover the level of supervision and wraparound fidelity training and support that will be required. Any additional supervision costs will be subsidized by the CMO, and the wraparound fidelity will be covered within the funding for administration.

The DHS design for Phase 1 of the Statewide Children's Wraparound Initiative intentionally does not significantly change the payment methodologies for the spectrum of services that may be accessed by the children and youth qualifying as Cohort 1 for this Phase. Rather the design invites a radical change in how local systems of care are organized and administered. The heart of the financial viability of MV-WRAP is more about the agreements developed through this planning process than the unfettered commitment of dollars from various sources, however the financial plan can be described in three categories: redeployed funds, coordinated services and in-kind contributions.

Redeployed funds

The Project Planning Team (PPT) had extensive discussions to reach consensus on the MV-WRAP admission criteria given in Readiness Section IV.2. MV-WRAP members may also qualify for New Solutions; the MV-WRAP criteria are not prejudicial in either direction regarding New Solutions members. The entirety of funding which MVBCN would provide for care coordination for MV-WRAP members will be received by MV-WRAP and available for purposes described at the very end of this section. PPT and

New Solutions staff have reviewed a variety of named lists of MV-WRAP qualifying foster children in DHS custody for this region and believe that 30 to 40% of the MV-WRAP members will also be in New Solutions. This would result in a redeployment fund in the range of \$300,000 to \$400,000.

In future phases of the Children's Wraparound Initiative we hope funding flexibility will be expanded by the state and that the "redemption fund" will grow dramatically through this flexibility and the reduction of use the most expensive services.

Coordinated services

The primary thrust of high fidelity wraparound services for the MV-WRAP participants is to provide them the best opportunities to be connected with people who care about them, achieve life-long social, vocational, and academic skills and have hope for the future. Paid services have a time-limited place in this objective. The spectrum of services that might be imagined by a child and family team for a particular individual is too extensive to try listing here, but there are some categories to be mentioned.

Oregon Health Plan – MVBCN is committed to providing all the mental health services (outpatient, inpatient, intensive treatment services) which may be indicated by the mental health needs of a MV-WRAP participant. As described Readiness Section III.5 the primary Fully Capitated Health Plans in the MV-WRAP region intend to do their best to coordinate general health and chemical dependency treatment services with MV-WRAP efforts.

DHS System of Care and other flexible funds – DHS district leadership for MV-WRAP is committed to the ready utilization of this highly flexible funding to support the success of MV-WRAP participants. These funds can be used to purchase services for both youth and their families, which are not covered by OHP. Examples include therapeutic supports, educational supports, mentoring, training, and activities specifically related to skill building or socialization. DHS also will provide flexible funding that supports families in their reunification efforts. Examples include help with housing and utility costs, transportation, and anything else that specifically relates to reunification needs. There may be some use of these funds for part of the activities described at the very end of this section; this will have the effect of increasing the dollar total given above for the redeployment fund.

Non-OHP alcohol and drug and other mental health services – The five MVBCN community mental health programs are functioning also as the MV-WRAP CMOs. They are committed to making these services readily available. However, since Phase 1 MV-WRAP participants are typically in DHS custody and out-of-home placement, they will qualify for OHP and MVBCN membership.

Yamhill County treatment foster care – the Yamhill County contract with DHS includes description of treatment foster care services. The funding does not come directly to Yamhill County for these 7.3 beds, but the authorization for placement is

done locally in coordination with system partners. These Yamhill partners have committed to making this resource available for MV-WRAP participants.

DHS Child Welfare funded services – Foster care and BRS foster care constitute a huge resource for MV-WRAP. Other available Child Welfare services (Family Based Services, 24-hour foster care crisis support, permanent foster homes and Foster Parent Night Out) are detailed in Readiness Section IV.7 and not repeated here. The heart of the MV-WRAP proposal is the co-management of this system of care, and most certainly these Child Welfare services are available for MV-WRAP participants.

Other system of care contributions – As described above in this Section, the Project Planning Team has engaged a wide variety of committed partners who have pledged to support MV-WRAP by providing and adjusting their current services for the benefit of MV-WRAP participants. Notable among these pledges are those from Catholic Community Services (CCS). CCS has pursued a vision similar to MV-WRAP for many years and has developed a range of resources and initiatives that will benefit MV-WRAP participants. These contributions are detailed in Readiness Section I.2; they include: the Fostering Hope Initiative, Family Life Lines (supported in part by RWJF-LIFP), Community Respite Home at Rainbow Lodge, and Community Homes for Children.

In-kind contributions

MV-WRAP plans to develop a process for quantifying the in-kind contributions during the first year of operations. MV-WRAP expects that the dollar value of these contributions will be substantial because management of a genuine system of care requires direct involvement of the partners in a variety of activities. Some of the high value contributions can be anticipated as follows.

Child and Family Teams (CFT) – a typical CFT will include two professional members beyond the DHS and MV-WRAP staff; for 90 minute meetings, twenty-four per year, 180 separate CFTs and \$43 / hour cost for professional hour, this multiplies out to over a half million dollars which will be donated by the system of care partners.

Community care coordination committees – in Marion County this group meets weekly, monthly in Polk, Linn and Yamhill Counties, quarterly in Tillamook County; on average the groups include 7 professionals, 4 in Tillamook; practice varies across counties for meeting lengths between one to three hours; at the \$43 / professional hour used above, this in-kind contribution will exceed seventy-two thousand dollars.

MV-WRAP Advisory Council – this monthly two-and-a-half hour meeting will include approximately 12 System of Care professionals beyond MV-WRAP-paid partners and advocates paid stipends; at the \$43 / professional hour used above, with some allowance for travel this in-kind contribution will exceed twenty thousand dollars.

DHS contribution of space and infrastructure – The five DHS Counties embrace the co-location of mental health staff in DHS buildings when possible. DHS will do this more as space allows; providing access to equipment and supplies.

MVBCN as the ASO – MVBCN will provide some infrastructure support for MV-WRAP operations. MV-WRAP administrative activities will use the MVBCN phone system and published phone numbers, the Internet-connected servers (hardware and software), the office space and general office support, MVBCN banking and fund management systems, and the same contracted claims payment system. These will be entirely donated, or provided at a very low marginal cost.

Community contributions – various community businesses and individuals are responsive to requests for donations; for example, a local Salem businessman regularly donates funds to sponsor activities for youth in foster care. There is no attempt here to anticipate the aggregated value of these contributions, but this is an example of what will be learned by the collection mentioned at the top of this subsection.

Administration

At the beginning of this Section it was noted that \$97,200 is anticipated for administration.

The central tasks for MV-WRAP include such activities as the following:

- Project liaison with DHS/AMH
- Provide materials and support for the Review Committee
- Support various other MV-WRAP committees, focus groups
- Conduct procurement of services and oversight of contract performance
- Coordinate education and training across the region, including publication of training opportunities offered by other organizations
- Develop and assure a variety of processes and protocols
- Participate in crafting an immediate crisis response for extraordinary situations
- Provide staff training and wraparound fidelity support
- Develop database(s) and data reporting for AMH and MV-WRAP committees
- Oversee data reporting for DHS and MV-WRAP committees
- Conduct accurate claims payment and tracking

MVBCN is prepared to accomplish these and other MV-WRAP administrative tasks. If this work cannot be done competently within the administrative funds offered by DHS, then MVBCN will draw from other resources to fully finance what is necessary. At this time MVBCN plans to use the Regional Children’s System Coordinator (New Solutions) to conduct most of these functions. Advanced administrative staff will be hired to relieve that Coordinator of some of the New Solutions administrative work and support the performance of MV-WRAP functions. MVBCN will engage additional database programming staff, at least for the start-up development.

The hopes for expanding existing services

Above in this Section there was a reference to redeployed funds. During this planning process many participants have made suggestions about additional services to facilitate the success of MV-WRAP participants (connection, skills and hope). The MV-WRAP Advisory Council will solicit additional suggestions, prioritize and direct prudent investment of the funds to be redeployed. Ideas that have been frequently mentioned thus far include:

- OFSN contract for facilitation of MV-WRAP Review Committee
- Recruitment, training and support of family and youth advocates
- Family and youth support partners available for all family and youth in MV-WRAP
- Family and youth peer services
- Education for primary caregivers
- Immediate access to shelter care
- Solid, accessible respite for foster providers
- Coordinate with and enhance DHS training for foster parents and BRS providers; pay for attending and provide back-up supervision during absence
- Crisis response teams to stabilize placements
- Enhanced Family Finders to go beyond what DHS can do now

III. Project Planning at the Policy & Administrative Levels

III.1. Describe how the project will implement a governance structure utilizing the Administrative Service Organization (ASO) model. Identify the ASO that will be heading up the project.

MV-WRAP has selected MVBCN, an intergovernmental organization formed by Linn, Marion, Polk, Tillamook and Yamhill Counties, to contract with the Oregon Department of Human Services to be the ASO (Administrative Service Organization) for the MV-WRAP demonstration. The MVBCN Board of Directors, the fifteen county commissioners from the five counties, will have the legal responsibility for the Project through the contract with DHS. See Attachment J for the Project Governance Structure.

MVBCN has operated as the OHP Mental Health Organization (MHO) for this region since 1997. MVBCN has developed the infrastructure, staff expertise, and critical partnerships to offer an excellent starting point for executing the ASO functions for this Demonstration Site. Specific areas of expertise include: Service procurement and contracting; policy development and implementation; quality assurance, training and support for service provider fulfillment of expectations; respectful resolution of disagreements and differences; and compliance with state and federal regulations, including due process rights and other federal Medicaid regulations. In addition MVBCN has developed sophisticated data management systems that will support the Project's success in: decision support and information for care coordination, fiscal management, and outcome and other state reporting.

MVBCN has a standing governance structure based on a strong culture of developing policies centrally while CMHPs have the flexibility to use local culturally responsive strategies and practices that achieve these policies. The MV-WRAP Advisory Council would be the primary central forum for:

- Policy development
- Service system planning
- Initiation and oversight of quality improvement initiatives related to MV-WRAP performance
- Pursuit of genuine system of care operations
- Design and implementation of communications and training
- Organization of ad hoc groups, forums and focus groups as needed to facilitate research and problem resolution

(These responsibilities are described in more detail in V – 1.)

LIVING VALUES

"I was lost, but now I am found". New Solutions helped both of us get through such a dark time. Without their guidance and resources, we would not have made the progress we have. Amanda probably would still be on probation and in and out of detention.

I know that I can trust and rely on New Solutions for any kind of help we need—anything from counseling to resources to help us at home.

Suzanne Thomas
Grandparent Advocate
Yamhill County
Grandparents Raising Grandchildren

The operational guidance for MV-WRAP will come from shared-decision making at all levels: the Child & Family Teams (CFT), the Local Care Coordinating Committees (CCCC), the Review Committee and the MV-WRAP Advisory Council.

The CFTs are the basic structure of MV-WRAP and will steer the treatment course. In accordance with high fidelity principles and practices, the CFT will guide the process by focusing all energies and strengths on the four phases of wraparound. A service plan will be developed for each child based on the unique strength and needs of the child and the strengths of other CFT members. The individualized needs of the child will be the primary focal point of the team's efforts to think creatively and outside the box. Natural Supports will be engaged and professional services will address these needs. The CFT will be able to make decisions during team meetings and commit project resources to meet the needs.

The CCCC will review the most complex situations or those requiring exceptional intensive services. The CCCCs will also be responsible for local practice decisions, and implementation of MV-WRAP policies, expectations and resource allocations. In addition, CCCCs are one forum for resolution of CFT disagreements. Some CMHPs will have separate appeal bodies with membership including family/youth and other system of care partners.

The MV-WRAP Review Committee will make decisions regarding entry and transition from the project. The Review Committee will help identify system issues and recommend improvement to the service array. The Review Committee will have a direct liaison with the MV-WRAP Advisory Council. The MV-WRAP Advisory Council will develop policies and an array of services to meet the needs of the Phase 1 cohort.

The MVBCN as the ASO for MV-WRAP will be the central administrating entity for the Project. With its experience as an Oregon Health Plan Mental Health Organization, MVBCN has the infrastructure, staff expertise and practices to succeed with duties as described in II.1.

III.2. *Describe how the ASO will determine and monitor the cost of care per child*

MVBCN has been chosen to perform ASO functions because most of the ASO functions are already performed by MVBCN for children's intensive services (MVBCN's New Solutions). Tracking cost of care is one of these functions. Since 2005, MVBCN has provided a care coordination and management decision support system throughout the MVBCN region. This system provides secure Web access for data input and report generation. Care coordinators use this system to track family team members and the course of care for a member. The database documents assessments, progress reviews, and service authorizations. Local and regional managers can review current authorizations and cost reports by member, service provider, region, etc. MV-WRAP will use this same database and have access to the same sophisticated reports.

In Phase 1, MVBCN will not be directly paying for many of the services received by the MV-WRAP members. The cost and value of securing payment information from other systems will be evaluated. The type and extent of services not paid by MVBCN will be recorded in the system described above. The current system easily incorporates estimated daily costs and computes the cost of a course of care, so that can be done. Automating the transfer of expenditure information from state payment systems to MVBCN may not be done in the first year, but the conversation will begin.

These reports will be available throughout the MV-WRAP distributed decision-making structure as indicated. Specific reports will be developed to inform the research and quality improvement endeavors of the various bodies and functions.

III.3. *Describe how the ASO will enter into Memoranda of Understanding (MOUs) with system partners to include child welfare and mental health agencies and providers.*

Stakeholders who signed the MV-WRAP Letter of Intent participated in a series of meetings across the MVBCN region in preparation of this proposal. Youth serving agencies, mental health and behavioral rehabilitation providers, OFSN and other family/youth participated in the design of this project and signed statements of support. We will build on MOUs developed for New Solutions in 2006 and by Willamette Education Service District in 2008. We will expand the CMHP agreements with Child Welfare.

Upon notice of selection as a demonstration site, the ASO will convene workgroups on a regional basis to update existing memorandums. These workgroups will address the needs of the cohort population and ensure foster parent and family/youth involvement in the process. The MOUs developed will:

- Identify barriers to be addressed
- Describe the need and value of integrated services and ask for a commitment to shared decision making and responsibility for outcomes
- Define roles and responsibilities
- Promote communication & information dissemination between system partners
- Provide direction and protocols for crisis situations
- Outline the dispute resolution process
- Outline process for cross training of staff.

III.4. Identify local funding sources. Clearly describe the investment of ASO, Mental Health Organization (MHO), Community Mental Health Program (CMHP) and Child Welfare resources that are directed to the project and the cohort of children identified in the project.

The Statewide Children’s Wraparound Initiative fund is the only new financial support for MV-WRAP. We have not identified specific local funding sources at this time.

Utilizing MVBCN as the ASO and leveraging the New Solutions infrastructure will enable some MV-WRAP administration to be done at a very low marginal cost, so this is a significant in-kind ASO/MHO investment in the project. To a lesser extent this will be true at the Community Mental Health Program (CMHP) level as well.

The MV-WRAP participants are by Cohort definition in Child Welfare custody and members of MVBCN. Therefore, they all are eligible for a spectrum of services from both organizations. The Child Welfare, MHO and CMHP contributions are described in detail in Sections II.1 and IV.7 so will not be repeated here.

III.5. Describe coordination with and access to services (such as primary care, medication management, addictions treatment) that are the responsibility of the Fully Capitated Health Plans (FCHPs).

For the MV-WRAP five-county region, the December 2009 Fully Capitated Health Plan (FCHP) enrollment report shows that all 15 FCHPs have at least a few members on record. However, over 86% of the FCHP-enrolled OHP members from the region are enrolled with either InterCommunity Health Network (IHN) or Marion-Polk Community Health Plan (MPCHP). MVBCN has a variety of health care integration initiatives underway with IHN and MPCHP, and active, collaborative relationships built over time. Collaborative Performance Improvement Projects with each organization have demonstrated the ability to design and deliver sophisticated integrated interventions, and have led to strengthened partnerships. Both IHN and MPCHP have discussed the MV-WRAP application and have expressed their willingness to coordinate general health care services with the other services and supports.

Policy issues regarding coordination and access to FCHP services will be a duty of the MV-WRAP Advisory Council. FCHP representation in that group will help assure appropriate policies, coordination and outcome monitoring. At the CFT level, team members will identify needs and determine when and how FCHP services may be accessed.

MVBCN is subcapitated by MPCHP for chemical dependency services. Therefore most MV-WRAP participants needing chemical dependency services will have direct access to services through MVBCN providers. Coordination of care will be enhanced

by the MVBCN's integrated co-occurring disorders programming, co-location of staff, and coordination of treatment planning. Ongoing training of chemical dependency and mental health providers and quality improvement efforts will focus on this population. MVBCN outpatient providers commit to participating on CFTs and coordinating care with Child Welfare and other system of care providers through the wraparound process.

Relationships have developed over time between the MVBCN and primary care. Coordination activities, such as on-site mental health consultation at primary care offices, improve access to needed services and coordination of care. Currently mental health staff are co-located at three pediatric and primary care clinics serving children and families in Marion and Yamhill Counties. Since 1998 MVBCN has had standards and monitoring processes to ensure that mental health and addiction treatment staff communicate with primary care providers. This occurs at intake, whenever there is a significant change in prescribed medication, and at the end of treatment. The Youth Services Survey for Family members (YSS-F) conducted by Acumentra in the summer of 2009 found that 93% of parents whose children were served by MVBCN were satisfied with the coordination of care between the mental health system and their Primary Care Physician (PCP).

III.6. *Describe how the ASO (BCN) will partner with and identify family members and youth who have had personal experiences with emotional disorders*

Family/youth involved with policy and local practice groups will be recruited from people who have participated in the wraparound process. These individuals will come from past and current users of New Solutions, EAST, and MV-WRAP. Also, with growing partnerships such as with the Marion-Polk Foster Parent Association, Yamhill Grandfamilies, OFSN, Juntos Podemos, and Youth MOVE Oregon we will bring more family/youth into our partnerships. These folks will come from those who attend workshops, support groups, and family/youth fun activities. Opportunities will be offered regularly for those interested in getting further involved in system change.

MV-WRAP will continue to include family/youth input at every aspect of this project. Family/youth will receive training (see IV.5) and continue to be included in developing policies, agreements, and materials (brochures, handbooks, etc). Family/youth will be on interview panels for MV-WRAP positions, on design and selection committees for RFP's and RFA's, and on writing teams for grant proposals, etc. Family/youth will also serve on governance structures such as:

- MV-WRAP Review Committee
- MV-WRAP Advisory Council
- Quality Assurance/Improvement Committees
- CCCCs

The long-term vision of the PPT is to have an integrated system of care. We expect that further expansion of the system of care will happen. We also expect to have more family/youth trained and involved in system change efforts. For the future, we will

advocate for system of care partners, such as Child Welfare and Schools, to include family/youth in their projects and agency-specific committees.

Family members and youth will train professionals on family culture. MVBCN family advocates currently do this regularly through the “Wisdom from Parents” training. MVBCN is sharing the use of this training with OFSN so family advocates across the state can use this professional workforce development tool. MVBCN and OFSN are supporting regional youth and young adults who are in the process of creating a similar “Wisdom from Young Adults” training curriculum. This curriculum is expected to be completed by August 1, 2010.

III.7. *Describe how the ASO will ensure that policies and procedures are culturally competent and that services are provided in a manner compatible with a family’s cultural beliefs, practices, literacy skills, and language.*

The Office of Minority Health has developed standards related to provision of National Standards on Culturally and Linguistically Appropriate Services (CLAS). See Attachment K. A primary goal for MV-WRAP will be to develop policies and protocols that ensure employees of the ASO and CMHP are culturally responsive according to the 14 CLAS Standards. A Cultural Responsiveness Committee will conduct a baseline survey of needs according to the CLAS Standards during the first 3-6 months from notification of funding. They will develop recommendations based on findings relative to the CLAS Standards. The Committee will define performance indicators, monitor fidelity, and evaluate outcomes. Outcome measures for cultural responsiveness will include: customer service; community and peer-based service delivery; proficient language capacity for staff; diversity of staff within mental health agencies; inclusion of culturally responsive assessment and customer service in staff performance evaluations; and outreach to diverse communities.

The MVBCN Quality Improvement Plan (QIP) currently includes an objective to maintain access to Mental Health and Chemical Dependency services for Spanish speaking and Hispanic enrollees. The presence of Spanish speaking staff at all levels of care (in-home skill builders, therapists, medication management and chemical dependency staff) ensures culturally responsive and linguistic capable care. Other strategic goals for improving cultural responsiveness will be added to the QIP. Participating counties will be accountable to the ASO for making these improvements identified by the QIP.

The Counties in this project are a mix of rural and urban communities and have a number of Tribal, Latino, Russian, Asian, African American, and other minority ethnic members. The geographical area stretches from Detroit Lake east of Salem to the ocean west of Tillamook, and Rex Hill north of Newberg to the end of Linn County south of Harrisburg. See Attachment L for profile of the region. The region has a culturally diverse representation of young adults who are or have been in the foster care system,

foster parents, family advocates, ethnic representatives, and family members with children who have high mental health needs. Our region has 16.6% of the entire Oregon population, and we have 24.5% of Oregon's Latino population. We have disproportionate levels of poverty and numbers of children in our region compared to other areas in Oregon. All of these aspects of culture will be considered in finding family advocates to participate on the governance structures. Data related to demographics will continue to be monitored.

As previously mentioned, two of the five MVBCN Counties (Tillamook and Marion) are participating in a Casey Family pilot site grant aimed at identifying disproportionality of foster care placements for ethnic minority children. The pilot has identified both African American and Native American children with over-representation in foster care. The work of this committee, which includes case audits to identify themes and reasons for the disproportionality, will be incorporated into the MV-WRAP QIP goals regarding cultural responsiveness.

III.8. Describe how services in the Service Coordination Plan will be authorized and how much authority the Child & Family Team will have to authorize services.

MV-WRAP will expand MVBCN's New Solutions procedure and authority for service authorizations that has been in place since 2005. The MV-WRAP will include the Child Welfare resources such as the System of Care funds and Family Based Services. The *Authorization Matrix* clearly delineates that the CFT will make decisions about the vast majority of individualized services and supports. Only services at the higher level of care will require the local CCCC involvement, and Child Welfare supervisory or ASO approval. CCCCs are designed to provide practice-level consultation and problem solving to CFTs and assist in identifying community resources.

The Authorization Matrix is on the next two pages:

Mid Valley WRAP Authorization Matrix

Type of Service	Who requests the service or helps decide what is needed	Who has authority to authorize service	Who reviews the treatment progress	Usual authorized amounts	Who develops the service (RFP, contracts)	Who pays for services/assures data input/Issues Notices of Denial
Inpatient hospital	CFT, crisis staff	ASO Inpatient Liaison	ASO Inpatient Liaison, CFT	Several days at a time	ASO	ASO
Sub-acute	CFT, crisis staff	ASO Regional Coordinator	ASO Inpatient Liaison, CFT	Days or one week at a time	ASO	ASO
Psychiatric Residential	CCCC, CFT	ASO Regional Coordinator	ASO Regional Coordinator /CFT	Weeks or month at a time	ASO	ASO
Day treatment	CCCC, CFT	ASO Regional Coordinator	CFT	Weeks or month at a time	ASO	ASO
Treatment Foster Care (diversion and step down from residential)	CCCC, CFT	ASO Regional Coordinator /CFT	CFT	Weeks or month at a time	ASO	ASO
BRS Therapeutic & Enhanced Therapeutic Foster Care	CFT	DHS	CFT	Weeks/months	DHS	DHS
BRS	CFT	DHS	CFT	Months	DHS	DHS
New Solutions in Psychiatry	CFT	CFT	CFT	Hours	ASO	ASO

Mid Valley WRAP Authorization Matrix

Type of Service	Who requests the service or helps decide what is needed	Who has authority to authorize service	Who reviews the treatment progress	Usual authorized amounts	Who develops the service (RFP, contracts)	Who pays for services/assures data input/Issues Notices of Denial
Crisis respite (out of home)	CFT	CFT	CFT	One or a few days	ASO/DHS	ASO/DHS
Brief/periodic planned respite - out of home	CFT	CFT	CFT	One or a few days	ASO/DHS	ASO/DHS
Crisis respite support - in home	CFT	CFT	CFT	One or a few days	ASO/DHS	ASO/DHS
Intensive community based services & supports	CFT	CFT	CFT	Hrs per week and number of weeks	ASO/DHS System of Care (SOC) Family Based Services	ASO/DHS
Mentors	CFT	CFT	CFT	Hrs per week and number of weeks	ASO/DHS SOC Family Based Services	ASO/DHS
24/7 crisis support	CFT	CFT	CFT	Hours or days	ASO/DHS's CCS contract District 3	ASO/DHS
Routine outpatient, in-home /school services for child & non-OHP parents	CFT	CFT	CFT	Hours per week and number of weeks	County/DHS System of Care Family Based Services	County/DHS
Flex funds	CFT	CFT	CFT	\$XX or \$XXX	N/A	County/DHS
Natural Support Programs	CFT	CFT	CFT	Hours or days	ASO	ASO

III.9. Describe how the ASO will evaluate project outcomes identified in the Statewide Children’s Wraparound Initiative.

The DHS Statewide Children’s Wraparound Initiative procurement packet includes a document entitled “Outcome Measures”. Other sections of the packet have implied desired outcomes. The MV-WRAP Advisory Council and other parties connected with MV-WRAP will be interested in monitoring additional outcome measures.

In 2005 MVBCN developed a care coordination and management decision support system. It was named the Children’s Intensive Services database system (CIS db). The system provides secure Web access for data input and report generation. Information about members in MV-WRAP will be entered into the database. All data will be reported to the state as required.

The plans for gathering data on the outcomes listed in the DHS Outcome Measures document are as follows:

LIVING VALUES

Care coordination is critical to the success of children being served across multiple agencies. Dayton School District believes that the regional application will foster collaboration with Child Welfare as well as among other child serving agencies and schools.

**Janelle Beers, Superintendent
Dayton School District, #8**

1. Children are getting their treatment needs met

- Compare percentage for each DHS branch prior to MV-WRAP to six months after full implementation, counting children in substitute care who receive mental health assessments and behavioral health services
- DHS / MV-WRAP will conduct and report on a representative sample of case reviews for the MV-WRAP participants

2. Children are able to reside in a stable, homelike environment

- The DHS Child Welfare data system provides information on each of the sub-topics listed for this topic in the “Outcome Measures” document; that information will be transferred to MVBCN and reported out
- Report on number of children who move to more homelike environment as a result of MV-WRAP services
- Report on number of placement changes averted as a result of MV-WRAP services
- Report on the number of new services and placement options developed each quarter through MV-WRAP operations

3. Children are safe

- MV-WRAP report on DHS Child Welfare data system information about documented abuse of MV-WRAP participants

4. Children are receiving culturally specific services

- Conduct and report on case review of the population.

- 6-month document review and observation by MV-WRAP Coach for culturally competent services and results of biannual Wraparound Fidelity Index findings which measure progress and satisfaction

5. Children are not engaged in problematic behavior

- Results of state quarterly report of BERS and SCWI Progress Review that measures delinquency, risk of self-harm, risk of danger to others and risk of running away

6. Children are making educational/vocational progress: Evaluated by the child and family team as well as the BERS and SCWI Progress Review item 9 (b) that measures educational/vocational progress

- Entered into and reported from the CIS db

7. Children are receiving social/interpersonal support: Determine whether the child/youth and family have positive and healthy attachments to each other and in the community.

- Results of state quarterly report of BERS and SCWI Progress Review item 9 (a) that measures social networks
- Entered into and reported from the CIS db

8. Children are experiencing improved behavioral health

- Compare percentage for each DHS branch prior to MV-WRAP to six months after full implementation
- Results of state quarterly report of BERS and SCWI Progress Review item 9 (c) that measures substance abuse
- Entered into and reported from the CIS db

Examples of additional measures that may be adopted by the WRAP Advisory Council include property damage, threats and intimidating behavior. The Advisory Council will also review currently available data sets. For example, extensive information is compiled for the biannual case reviews conducted by the Citizen’s Review Board and the Child and Adolescent Needs and Strengths (CANS) assessments that are conducted for each child in foster care.

III.10. Describe how the project will ensure that Medicaid regulations are adhered to.

As the ASO the Mid-Valley Behavioral Care Network will use its current Medicaid compliance infrastructure to assure fulfillment of Medicaid regulations. To succeed as a Mental Health Organization (MHO) MVBCN has implemented internal and external systems for monitoring Medicaid compliance. For examples, MVBCN centrally manages assurance of the due process rights of OHP members regarding unilateral

denial or changes in service. MVBCN administers a Fraud, Waste and Abuse Committee with membership including the MHO, LMHA, compliance officers and providers from the five-county region. This committee oversees compliance with Medicaid regulations regarding the prevention and detection of fraud, waste and abuse. A variety of Medicaid requirements are specified in provider contracts and compliance is reviewed by annual site visit. MV-WRAP operations will be included in all compliance processes.

IV. Project Management at the Service Level

IV.1. *Describe how the project will implement a governance structure that incorporates the functions of a Care Management Organization (CMO).*

Care management responsibilities will be provided by the five CMHPs that comprise MVBCN. Linn, Marion, Polk, Tillamook and Yamhill counties will build on the existing strengths of an administrative infrastructure and service system designed to deliver and sustain fidelity to the wraparound model. These counties have demonstrated competence in integrating system of care core values and the 10 principles of wraparound (described in section I.1, I.2). All five CMOs have utilization review systems in place and research based outcome monitoring and evaluation. The CMOs will guarantee a high-quality team process following the four phases of wraparound inclusive of a positive behavioral support plan, detailed safety planning and a prioritization of educational/vocational needs.

Since meaningful family and youth participation contributes to high quality planning and positive outcomes, a primary task of the CMO will be to ensure that family and youth are primary decision-makers not only on their Child & Family Teams, but also in the development and implementation/modification of the local system of care. Intentional strategies will be employed (see IV.5).

The managers at CMOs and Child Welfare Districts 1, 3, and 4 have agreed on the importance of maintaining consistency and continuity of relationships for the cohort populations. In support of meaningful attachments and improved proactive safety planning, leadership has agreed to strive to co-locate project staff, train all staff in fidelity wraparound model, assign staff to the project that have a commitment and belief in the system of care core values and wraparound principles.

IV.2. *Describe process for identifying children that will be served under the project, and screening tools used for access and intake.*

The project will serve a combination of youth who are already in DHS custody and meet the cohort criteria as well as youth coming into the system during phase 1. The review committee will review all referrals and determine whether they fit the cohort criteria and if so, whether the youth would be appropriate for the program using the below guidelines to help prioritize. Youth with the least amount of stability will be considered first but other factors such as family involvement, natural supports, and location may also be taken into consideration.

The five individual Child Welfare branches will be responsible for making the referrals to MV-WRAP. Each branch will develop an internal process for determining when a youth is referred. At a minimum this decision process will include Supervisory support.

For children already in DHS custody, the following guidelines will be used to help prioritize referrals to the project until it reaches capacity enrollment.

- The youth has been in care for at least one year, has had four or more placements, has behavioral, emotional, and or mental health conditions warranting specialized treatment services (includes BRS, shelter evaluations, psychiatric residential, treatment foster care, or ICC) AND is presently not in a stable placement.
- The youth has been in care for at least one year, has had four or more placements, has behavioral, emotional, and or mental health conditions warranting specialized treatment services (see above) AND the current service array is deemed to not be effective.
- The youth has behavioral, emotional, and or mental health conditions warranting specialized treatment services (see above).
- The youth has been in care for at least one year and has had four or more placements.

For new youth coming into custody, the following guidelines will be used to help prioritize referrals to the project until it reaches capacity enrollment.

- At the time of placement, the youth already receives Intensive Community Based Treatment Services from the mental health system.
- The youth has behavioral, emotional, and or mental health conditions warranting direct entry into specialized treatment services (see above).

Each branch will be responsible for providing the review committee with written screening materials they have in their possession. Included will be a cover page that will provide key demographic information about the child such as location, names of the caseworker, foster parents, involved family members, other natural supports, and permanent planning information. Attached to the referral page will be any psychological evaluations, mental health evaluations, CANS assessments, CASII assessments, ECSII assessments, shelter evaluations, treatment reports, social histories, medical and developmental histories, and placement histories. Existing case material from county mental health records will also be used in the screening process.

IV. 3. Describe how the ASO will establish a Review Committee to approve participation in the project prior to entry into and transition from the project and adhere to federal and state confidentiality requirements.

MVBCN will establish a regional Review Committee, facilitated by OFSN ensuring 51% advocate representation. It will be comprised of a Regional Resource Consultant and line supervisor from Child Welfare, an ASO representative, a Wraparound Supervisor from one of the Community Mental Health Programs and four parent/youth advocates. The Review Committee will review all available referral information, and approve all project entries to and transitions from MV-WRAP. The Review Committee Facilitator will guide a structured staffing process in order to ensure shared decision-making. Family and youth advocate involvement will be critical to effective prioritization of referrals and creating a new perspective for making recommendations.

MVBCN will be responsible for collating all referral information for the Review Committee, managing meeting logistics and providing technical support. In addition, MVBCN will provide training as needed to participants on the committee to ensure that all parties understand and adhere to federal and state confidentiality requirements and sign all appropriate confidentiality agreements.

In addition to the Review Committee’s primary role of enrolling and transitioning project participants, they will be part of the MV-WRAP system improvement process. When a placement changes, the CFT and local CCCC may conduct a retrospective review of what happened in order to prevent future unplanned placement changes and to identify systems barriers or issues. Members of the CFT will present the information and recommendations generated from their retrospective review to the Review Committee. MV-WRAP’s Review Committee will be responsible for monitoring patterns in the retrospective reviews and identifying opportunities for systemic improvement in policies, procedures, services and supports. The Review Committee will report trends and make recommendations to the Regional Advisory Council for consideration of program or policy change as part of the quality improvement process.

IV.4. Describe how the CMO will implement a wraparound planning process that includes a strengths-based needs assessment, child and family team facilitation, and care coordination.

All five CMOs involved in MV-WRAP are currently providing high fidelity wraparound to children with significant emotional and behavioral challenges. Since

LIVING VALUES

When she first started with NS she was angry and violent, pushed grandma down the stairs and got in to fights over simple things. Now she has an even temper, she has learned to accept frustration and disappointment and just move past these difficulties.

“The team gave me the confidence to stand up for myself and do things on my own--having those people cheering me on so I CAN do it,” she said.

**Notes from a graduation celebration
New Solutions**

research has demonstrated it is high fidelity wraparound that produces improved outcomes for children and families, all five CMOs have committed to staffing MV-WRAP using a combination of currently credentialed wraparound facilitators and facilitators in training to maximize the delivery of this evidence based practice when the project starts on July 1st. The Regional Wrap Trainer, the Wrap Coach and the county project managers have committed to implementing enhanced supervision and support to credential new Wrap Facilitators within 5 months of hire.

In accordance with the high fidelity model, MV-WRAP will staff CFTs with Family Support Partners and Youth Support Partners depending on the needs of the child and family. The project will use a combination of current Family and Youth Support Partners from the CMOs and additional staff recruited through expanding the MVBCN contract with OFSN.

IV. 5. *Describe how the ASO/CMO will designate family members and youth in the primary decision makers and ensure that planning, development, and implementation of the local system of care is family-driven, and youth-guided. Include family member/youth participation on child and family teams and provision of peer support to families/youth participating on child and family teams.*

To ensure that meaningful family/youth involvement will be a part of the local and regional change to a system of care, it is helpful to first look at common barriers, and those solutions in place already, or being considered:

Common Barriers	Solutions
<p>Privacy/HIPAA concerns: a concern for some professionals is that family/youth will not be able to keep information confidential</p>	<p>Advocates will be trained regarding confidentiality laws and sign a confidentiality agreement. Releases of information will be used when assisting families or when reviewing specific cases.</p>
<p>Background checks: many families/youth may have child welfare and/or criminal histories due to the life experiences that make their voice so critical to have as part of system and service delivery planning processes</p>	<p>For background checks through peer support organizations e.g., OFSN and Project: A Better Life Experience (Project ABLE), it is understood by being a peer, there may be negative history. For those with a negative history, positive changes in their life’s direction must be demonstrated for a significant period of time and supervision will be increased.</p>

<p>Time of day of the meeting: many families and youth find it difficult to attend during traditional business hours</p>	<p>Meetings need to be between 10 am-2pm or 6 pm or later to ensure meaningful family involvement. Some youth may have difficulty with daytime meetings due to school demands. MV-WRAP will partner with willing school districts to develop creative strategies for youth involvement.</p>
<p>Transportation/travel needs: for some family/youth getting mileage reimbursement isn't always enough, especially for those without driver's licenses or their own vehicle</p>	<p>Transportation solutions include carpools, bus passes, gas vouchers, and selecting meeting locations close to public transportation stops.</p>
<p>Childcare: many can't find adequate childcare, even if money is provided to cover it</p>	<p>Childcare will be provided for evening meetings.</p>
<p>Location of Meetings: clinical locations may be re-traumatizing; especially for those who have had negative experiences, particularly in connection to psychiatric crisis or child welfare involvement</p>	<p>Neutral places such as community centers, libraries, coffee houses, etc are preferred. Efforts will be made to find these types of locations for meetings.</p>
<p>Representation from minority cultural groups: it is a national issue regarding the difficulty of ensuring representation and being culturally responsive for the vast array of cultural groups and contexts</p>	<p>MV-WRAP plans to include families/youth from all races and ethnicity such as tribal, Latino, Russian and Asian communities. MV-WRAP is aware that minority cultural groups include more than race and ethnicity. We strive to have diversity in religious representation, socio-economic groups, formal education backgrounds, family structure, and sexual orientation.</p>

We will recruit family/youth from past and current participants in the wraparound process and from local peer support groups as described further in the answer to III. 6. These individuals will receive project, system and wraparound training. In partnership with OFSN, trainings will be available such as “Families and Professionals as Policy Partners”, “Youth and Professionals as Policy Partners”, “Journey to Advocacy”, and peer-led “Collaborative Problem Solving Book Clubs”. Families/youth will be invited to attend pertinent professional trainings on topics such as trauma-informed care, collaborative problem solving, mandatory reporting, and HIPAA requirements.

Having a collaborative team-based approach is important at the system level as well as at the CFT level. Team building activities will be part of each agenda which support the development of relationships between family, youth and professional committee members.

To ensure ongoing participation and in order to be sure family/youth advocates are not asked to do too much, efforts will be made to recruit several family/youth advocates for each group. Efforts will be made to support regularly scheduled family/youth leadership development opportunities and meetings.

Family/youth advocate committee members will have time to gather before meetings and preview agenda items. Advocates will also have time to debrief after meetings and review any action steps expected of them. They will also discuss possible future agenda items. As more family/youth advocates become involved, MV-WRAP plans to partner with OFSN to develop a peer-coaching model for regional and local family/youth advocates.

We know most committees have term limits for members. Due to crisis and other life events, many families/youth may not be able to serve without fail through a full term. Unless the family/youth have asked to be dropped from the committee, they will stay a member with a plan in place for having an alternate advocate attend. A plan will also be developed for recruiting and training new advocates when former ones leave the group permanently.

It is understood that there has traditionally been a power gap between professionals and family/youth. Many family/youth are hesitant to speak up when they are the only advocate voice in the room. MV-WRAP will use the same standards for representation as used by national system of care communities. We will have 51% family/youth members at the Regional Partners for Children’s Mental Health Committee, the MV-WRAP Advisory Committee, and the MV-WRAP Review Committee.

Community Care Coordination Committees (CCCC) will have significant family/youth membership. We will strive for 51% representation at the local level. For local committees, there will be at least four family/youth members. Only one may be an employee of the CMO. At least one member will have experience in the foster care system, either as a youth, foster parent, or parent whose kids have been in foster care. At least one member will represent a local cultural minority group. From past experience, decisions on committees are usually arrived from discussion and consensus. For those rare occasions when a vote may actually be taken, those committees without 51 % family/youth members will adjust the family/youth vote to be 51 %.

LIVING VALUES

The most profound result I have personally experienced from having the New Solutions program for my child is that I am no longer alone. I don't have to carry the burden of my child's severe mental health issues by myself. I am supported, listened to, and I receive positive feedback with all our difficult challenges.

L.V. Yamhill Co.

All MV-WRAP committees shall have at least one family/youth member as co-chair. Co-chairs will be part of the executive planning (agenda setting) team.

Other ways we will support meaningful family involvement include, but are not limited to:

- Post the Wraparound principles at every meeting
- Have small group activities/discussions
- Recognize and value life experiences of members, even if seemingly negative (ex drug addiction, criminal history)
- Empathy and stigma-busting activities

To ensure meaningful family/youth voice at the CFT level teams will use such strategies as:

- Team Vision and Goals are in language that is clearly understood by all team members
- Families create their own strengths, needs, and culture discovery (SNCD) to share through video productions, scrapbooks, collages/posters and cartoons
- Child and family speak first and last at team meetings
- Child and family are prepared for meetings
- Child and family are supported or coached during meetings
- Collaborative problem solving strategies are used to get to team member concerns or perspectives
- Collaborative problem solving strategies are used to be sure action steps are realistic for all team members to do
- Child and family help set the meeting agenda
- Support child and family in leading team meetings
- Draw out child and family strengths, needs, and ensure their voices lead the decision-making process (yes, even those parents struggling with their own recovery)
- If no child, youth, parent, family member, or foster parent is present; no decisions can be made
- MV-WRAP will follow the same high fidelity Wraparound standards that have been documented by New Solutions staff

The CCCC's often review cases when a higher level of care is needed. These are times when life is not going well for these children and families. CCCC members are often people in managerial positions, so the authority for making decisions is present. Due to this, they may be farther removed from the child and family and may not know them personally. The following are suggestions for making the child and family real to committee members, when placement decisions are being made at the CCCC:

- Begin every meeting with a success story (from a child and family that has been before the committee in the past)
- Share the SNCD created by the child and family
- Share child and family photos
- Share child and family strengths, the family SNCD project, child's artwork, child's poetry and "Who I Am" Video
- Have WRAP principles on every cover sheet of case file being reviewed

MVBCN has taken into consideration the overwhelming voice of families, youth, young adults, and adult consumers regarding the importance and value of peer delivered services. MV-WRAP will support the expansion of available peer delivered services. Examples of just a few of these desired peer resources are:

- Family Support Partners
- Youth Support Partners
- OFSN/YMO Peer Delivered Services
- Project ABLE Peer Delivered Services
- Local Youth Peer Groups
- National Alliance on Mental Illness (NAMI) –in communities with an active affiliate
- Mobile MH Crisis teams to include a peer advocate
- Mental Health Crisis Advocates (similar to Domestic Violence Advocates and Rape Victim Advocates working with Law Enforcement and Hospitals)

For children/youth to be successful in their communities, education for parents, foster-parents, and professionals is critical. MV-WRAP will provide regional education and training support for all CFT members and system partners. This support will include, but is not limited to:

- Current inventory of curriculum for families/youth/professionals through ORPTI, OFSN, CMHPS, MVBCN, NAMI:
- Support regularly scheduled trainings/workshops
- Track objectives and the intended audience for these trainings/workshops
- Offer joint family/youth/professional or combinations as possible; this may not always be appropriate.
- Ensure training opportunities for families/youth (on teams as well as on committees) and professionals,
- Preferred trainings will include a skills based assessment procedure

IV.6. Describe how the ASO/CMO will establish a provider network with access to care coordination and a full array of services and supports for the defined population of children in the community.

MV-WRAP will have full access to a rich array of services and supports already established throughout the five MVBCN counties outpatient mental health system and the five Child Welfare branches. Lessons learned from listening to families and youth in the CSCI implementation resulted in enhanced community based outpatient services region wide. For example, all five MVBCN CMHPs have incorporated individual and family skills trainers who work in diverse community settings.

MV-WRAP will utilize contracts developed under the CSCI with OFSN and providers of intensive community based services and intensive treatment services. These providers have established collaborative relationships and provide services such as family support programs, mentors, skills trainers, planned/crisis respite homes and treatment foster care. As described further in IV. 8, the ASO and Child Welfare intends to work with family and youth advocates and providers in developing an emergency response team and rapid access to placement services building on existing provider programs. The ASO also has a contract with a board certified child & adolescent psychiatrist. This physician provides in depth assessments of complex children often in the home/school of prioritized children; medication management and support to medical practitioners and consultation to CFTs. In addition, a portion of the grant will be used as flex funds to address the unique needs of children identified in the wraparound planning process.

IV.7. Identify the service array funded by DHS/CAF, DHS/AMH and DHS/DMAP that is available in the community, as well as services provided to the Phase 1 cohort by other system partners. Describe efforts being made to expand the diversity of the service array. Describe what evidence-based practices will be available through the project and how fidelity to the models will be achieved.

DHS/CAF funded services across the BCN region

- Family Based Services (in home parent mentoring, skill building, family therapy, reunification support)
- System of Care funds (flexible fund for goods and services connected to meeting the case plan goals)
- Mentors
- Treatment foster care
- Crisis placements via individual contracts
- BRS placements
- 24 hour crisis support
- Addiction Recovery Team

- Child and Adolescent Needs and Strengths (CANS) assessments for enhanced supervision
- Personal Care Assessments for enhanced medical care
- Administrative or Other Medical Services
- Independent Living Services and Subsidy
- Target Planning and Consultation
- Supportive/Remedial Day Care

Service array description available across the MV-WRAP region funded by DHS/AMH

Listed below are regional mental health evidence based models implemented with high fidelity.

Intervention	High Fidelity monitoring activities
Wraparound Model	<i>Wraparound Fidelity Index</i> , a six-month <i>fidelity review</i> process and an <i>Infrastructure Survey</i> completed by local Community Care Coordination Committees.
Parent Child Interaction Therapy (PCIT)	Clients meet mastery of the Child Directed Intervention (CD) and the Parent Directed Intervention (PDI) skills, the Early Childhood Behavioral Inventory (ECBI) scores are in the normal range, and the agency has final documents (ECBI, the final Dyadic Parent-Child Interaction Coding System (DPICS) with the 15-minute observation and the Parenting Stress Index – Short Form (PSI-SF).
Co-occurring disorder integrated care for mental health/chemical dependency	Drake Scale criteria reported in the Quality Improvement Plan
Early Assessment Support Team-EAST, to identify early psychosis and treat it assertively	MVBCN protocols
Strength Based Case Management	Fidelity Scale; Team based design; chart review
Dialectical Behavioral Therapy (DBT)	ACORN; Chart Review; practice specific clinical supervision
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)	Pre-post tests and attendance records and standardized curriculum
Functional Family Therapy	Data sets turned in to FFT developers
Medication Management	Med Map Fidelity Scale
Solution Focused Brief Therapy	ACORN; Chart Review; Practice specific clinical supervision
Eye Movement Desensitization Reprocessing (EMDR)	Manual with progress notes that track implementation

Multiple services and interventions are available in communities across the region to the Phase I cohort. Mental health outpatient providers offer:

- Infant Massage
- Collaborative Problem Solving (CPS)
- Strategic/Structural Family Therapy
- Seeking Safety
- Making Parenting a Pleasure
- The Incredible Years
- Brief Solution Focused Therapy
- Strengthening Families
- Post-Partum Depression Groups
- Motivational Interviewing and Stages of Change
- American Society of Addiction Medicine (ASAM) Patient Placement criteria
- Cognitive Behavioral Therapy for Anxiety
- Cognitive Behavioral Therapy for Depression

These are all methods implemented with supervision and oversight to maintain fidelity to evidence based models. Intensive mental health services such as residential, day treatment; acute hospital and long term state hospital are available regionally. The following services used as adjuncts to the evidence based models previously listed:

- Peer delivered services
- Adolescent sex offender therapy
- Community based wrap
- Respite
- In-home skill builders
- Mentors
- Psychiatric medication management
- Sensory diet strategies for emotional regulation
- Youth Transition Services
- Onsite mental health at DHS

DHS/DMAP funded services across the BCN region

Treatment foster care and shelter beds with Rainbow/Catholic Community Services
Outpatient mental health services across the region are available for open card clients

Services provided across the BCN region by other system partners

Peer delivered services via Oregon Family Support Network includes:

- Explosive Child Book Clubs and Support Groups
- School Based Health Clinics
- Respite Care programs by Catholic Community Services, includes Rainbow Lodge
- Adolescent Sex Offender Services

- National Alliance on Mental Illness (NAMI) Family-to-Family training
- Oregon Parent and Training Information Center (ORPTI) trainings

Efforts to expand the diversity of the service array:

In question II. Resource Plan, *The hopes for expanding existing service*, the list of expanded services MV-WRAP will redeploy is delineated. Additionally, other efforts may include:

- For cohort I children/youth, MV-WRAP will develop early intervention practices and flexible services and supports
- Regional efforts are taking place to design professional interventions and parental responses that enhance attachments to primary caregivers. A draft position paper is in the works. See Attachment M.
- Efforts to build natural supports and increase their involvement via action steps on the care plan.
- Psychiatrists attend team meetings; more frequent medication management, with second opinions a standard
- Efforts to find and involve family
- Training and Support for foster parents:
 - CPS training for all foster parents in the region
 - child specific training in the foster home
 - respite in form of mentors and Youth Engagement Specialists
 - 24-hour access to crisis services to talk through frustrations with a youth
 - Flex funds to keep foster families able to keep kids in home
 - Development of Wellness plans for children/youth that incorporate physical, mental and emotional aspects of care.

IV.8. Describe the plan to develop crisis/emergency services related to placement, treatment and service provision of a therapeutic nature that will be used for children served under this project. Describe the plan to develop mechanisms for rapid access to placement services if needed.

Upon notification of funding, the ASO, Child Welfare, and a diversified group of family, youth and foster care advocates will define needs and protocols around rapid access to placement services. The rapid access system will include immediate access to a team of skilled professionals prepared to stay in home of the child until the crisis is resolved and all parties feel safe and able to move forward. The ASO has flexibility with current contracts to expand crisis use within existing facilities and resources. This crisis placement will be defined as a short length of stay to afford the CFT time to convene and plan for a successful return home or if needed an alternative in the community. Existing resources for children who qualify for intensive mental health services will always be considered in appropriate circumstances.

The ASO is prepared to develop new contracts using an RFP process in the event current resources do not meet the immediate crisis needs of the child. The Project Planning Team has discussed various options and will engage youth, advocates, foster parents and providers in discussions on innovative services designs to meet these needs.

IV. 9. Describe how culturally competent services will be provided in a manner compatible with a family's cultural beliefs, practices, literacy skills, and language.

Wraparound Model begins with a Strengths, Needs, Culture Discovery process and document that is reviewed and signed by the family as an indication of satisfaction that the document adequately captures their strengths and needs within a cultural context. Wraparound Facilitators are trained and go through the process of accreditation to be proficient in delivery of this Phase I activity of Wraparound. It is a cornerstone upon which the CFTs are built. It is within that process that cultural beliefs and practices, and literacy and/or language needs are identified. Team planning develops goals and action steps that address these needs. Each goal incorporates the strengths that already exist within the child and family to address the identified needs.

Culturally responsive service provider qualities:

- is self aware and aware of others in a sensitive manner
- can develop strong relationships moving past stereotypes, assumptions, and judgments
- has team facilitation skills that can address conflicts in team meetings by listening, checking perceptions, moving conflicts from complaining to problem solving, and above all, making sure that family members voices are heard
- empowers families in their own language
- recommends culturally-specific services that include language, values and traditions of the family
- respectful
- creative problem solvers
- empathetic listeners
- open minded and patient

Every effort will be given to hire, train, and coach facilitators that embody these values and behaviors. As described earlier in this proposal in Section III.7, policies and procedures will be developed that follow Office of Minority Health CLAS. This will ensure the Care Coordinator staff who facilitates Child & Family Teams will be trained in cultural responsiveness and be provided with coaching and support to remain so. Reviews of cases will monitor for cultural responsiveness and work plans will be developed and monitored when staff are not responsive.

LIVING VALUES

"I didn't know a thing about mud-flap racing. The parent and extended family all were four-wheel drive mud flap racers. When I visited, they were very standoffish and reserved. And there were so many of them, I knew I needed to find a way to bridge the gap or I was not going to be able to help their teen daughter. After my first meeting, I went outside with the mother's partner, and he showed me his four-wheel drive. It was then that I felt the reserve lifting, and thought there was a chance we could help."

Wrap Facilitator

V. Project Oversight at the Policy, Administrative & Service Levels

V.1. *Describe how the project will implement a governance structure that includes the functions of an ASO Advisory Group.*

The governance for MV-WRAP will come from shared-decision making at all levels: the CFTs, CCCCs, the Review Committee and the ASO Advisory Group which will be named the MV-WRAP Advisory Council (WRAP AC). Please see Attachment J for the project governance structure.

Since January 2005 MVBCN has had an effective advisory group for New Solutions, the MVBCN program developed in response to the Oregon CSCI. This advisory group, the Regional Partners Executive Committee (RPEC), includes most of the membership expected by DHS for the new Children's Wraparound Initiative. A functionally separate group, the MV-WRAP Advisory Council (WRAP AC), will be formed from RPEC to guide the MV-WRAP; RPEC will continue with its current functions and the agendas and meetings will be organized to limit redundancy and maximize effectiveness. Please see V.2. for more information.

The MV-WRAP Advisory Council will be the primary central forum for:

- Policy development
 - Develop a thorough understanding of HB 2144 and the expectations of the DHS Statewide Children's Wraparound Initiative.
 - Design policies and directions which implement the plans described in the MV-WRAP proposal.
- Service system planning
 - Solicit and process ideas and recommendations from families and youth, system of care partners, MV-WRAP Review Committee, focus groups, ad hoc committees and others on the design of the MV-WRAP system of care and desirable services and supports.
 - Prioritize and direct the development of system of care enhancements.
 - Advise ASO (MVBCN) on the design, selection and evaluation of MV-WRAP services and providers.
 - Evaluate the alignment of providers and services with the system of care vision.

LIVING VALUES

In regards to the NS program, I only have compliments. It took a lot of effort on everyone's part, but it was well worth it. The support network completely kept AZ from "falling through the cracks" at school. I truly believe that he would not have the motivation and self-control he has right now, if not for the understanding and help that the entire team provided. Thanks again for all you did to help my guy!

Charlie Armfield
Yamhill County

- Initiation and oversight of quality improvement initiatives related to MV-WRAP performance
 - Receive and evaluate reports from ASO (MVBCN) and state agencies on the performance of all aspects of MV-WRAP operations throughout the region.
 - Receive concerns and suggestions from providers, stakeholders, youth, families and advocates.
 - Reflect on identified problems, research solutions, recommend responsive actions, and monitor results; praise examples of excellence.
 - Identify and make recommendations regarding work force development and training.
- Pursuit of genuine system of care operations
 - MV-WRAP members will actively endorse and promote the development of the MV-WRAP system of care by influencing their constituent groups or agencies
 - Receive feedback from partner agencies and community stakeholders by creating an atmosphere where diverse ideas and challenging input is encouraged and valued.
 - Evaluate functioning of local CCCCs and support their success in (1) achieving a local system of care, (2) providing practice-level consultation and problem solving to families, providers, child and youth serving agencies and child and family teams and (3) identifying needed community services and supports.
 - Provide information and feedback to the AMH, Child Welfare and other relevant state agencies on the successes and challenges of working with children and youth across systems of care; make recommendations regarding systems improvements.
- Design and implementation of communications and training
 - Oversee development of an ongoing strategic communication effort to inform all community partners, stakeholders, and potential service recipients about MV-WRAP services and the importance of a system of care approach for children and youth.
 - Ensure all communication is designed to increase understanding of natural supports, service coordination, community based services, and fidelity wraparound and their critical role in empowering children, youth and families to improve their lives.
 - Provide education, coaching and ongoing support for youth to develop leadership skills that enable them to utilize their perception and experience with the social service system to provide policy advice on MV-WRAP Advisory Council and other relevant committees and advisory groups.
- Organize ad hoc groups, forums and focus groups as needed to facilitate research and problem resolution

V.2. Describe how the ASO will establish membership in the advisory group to include 51percent family members and youth/young adults, and with attention to appropriate cultural/ethnic diversity representative of the community.

As mentioned in response to V.1, much of the membership of the MV-WRAP Advisory Council will come from the existing New Solutions RPEC. By charter that membership includes:

Advocates:	(total 14)
Parents (birth, adoptive, kinship)	7-9
Foster parent	1-3
Youth/young adults	2-4
DHS Child Welfare	1
OYA	1
Juvenile Justice	1
Schools/ESD	1
Local Mental Health Authorities	5
Developmental Disability Services	1
Alcohol and Drug	1
Physical Health Provider	1
Private Intensive Services Provider	1
Private Outpatient Provider	<u>1</u>
	28

The Regional Partners discussed membership changes and recommends the following for the MV-WRAP Advisory Council:

- Local Mental Health Authority, five seats will be reduced to two from the CMOs
- Add one representative each from the faith communities and from law enforcement
- Increase Child Welfare representation by at least one member from the case worker supervisor level

MV-WRAP plans to include families/youth from all races and ethnic groups such as tribal, Latino, Russian and Asian communities. MV-WRAP is aware that minority cultural groups include more than race and ethnicity. We will strive to have diversity in all areas including religious representation, socio-economic groups, formal education backgrounds, family structure, and sexual orientation.

The current Regional Partners membership agreed to increase the frequency of meetings and serve on this new Advisory Council. They also recommended contracting with OFSN for assistance with recruiting, training and supporting family and youth members.

MV-WRAP Advisory Council members will be appointed by the MVBCN Regional Advisory Council. Initial membership terms are for three years. MVBCN staff will provide meeting support for WRAP AC. The Council will elect two co-chairs; at least one will be a parent or youth/young adult. The co-chairs will establish the agendas for WRAP AC and facilitate the meetings.

V.3. Describe how the ASO will ensure that advisory group membership will be representative of community stakeholders with the authority to endorse and promote the project and development of the local system of care.

The RPEC has been successful in engaging management level representatives from the organizations listed in V.2. Recruitment for MV-WRAP Advisory Council (WRAP AC) members will continue to pursue professional members who have the authority within their agency to advance the activities of MV-WRAP. The charter for WRAP AC will specify that one of the activities of WRAP AC, and one of the responsibilities of members, is to promote MV-WRAP and the development of a local system of care.

ATTACHMENTS

Attachment A: Project Planning Team Membership

Attachment B: Wisdom from Youth Council

Attachment C: Fostering Hope Parents Council Focus Group

Attachment D: Behavioral Rehabilitative Services (BRS) and Mental Health ITCS and ITS Provider input

Attachment E: New Solutions Focus Group on Wraparound with Foster Kids

Attachment F: New Solutions Regional Meeting-Working with Child Welfare

Attachment G: Declarations of Support and Commitment to work with MV-WRAP

Attachment H: 2009 Wraparound Fidelity Index Summary Report, University of Washington

Attachment I: 2008 MVBCN Infrastructure Survey Report and Recommendations

Attachment J: Project Governance Structure

Attachment K: National Standards on Culturally and Linguistically Appropriate Services (CLAS Standards)

Attachment L: Population/Diversity Profile of Region

Attachment M: Draft--Best Practice Care for Children with Attachment Disorders

Attachment A: Mid-Valley WRAP Project Planning Team

We are pleased to submit this proposal from Mid-Valley WRAP to become a demonstration site for the Statewide Wraparound Initiative. We have committed our time and energy to develop a proposal that will help move our region and the State of Oregon towards a System of Care. We have recognized that system change needs to start with ourselves. We have many collective years of experience as youth, parents, foster parents and professionals in this work. However, we know that we need to listen intently to each other and creatively respond in a more effective way for the children and families served by this project.

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Attachment B: Wisdom from Youth Council

Community Home Youth Council Focus Group

February 16, 2010

What was helpful to you during foster care?

- Having help and services to transition into world and college was helpful.
- Independent Living Services and Youth Council
- Having Jim as mentor
- Because of Marcy (ILP) and Jim, she realized I had options such as college or jobs.
- Moving within the same county, and attending the same school helped tremendously. I was able to keep my friends and not change everything.
- I was able to live with my sisters in the last foster home: and that helped a lot.
- Having grandparents and uncles in my life.

Any ideas about how to help kids that move a lot?

- Redmond High School was broken into smaller blocks. The smaller blocks allowed me to succeed (it might have been also the new specialized curriculum). They had 10-15 kids instead of 40 per teacher.
- Learning Center like the one CCS has would have been helpful.

If you had a magic wand, and could make it better for the next person, what can we as professionals do better?

- Explain to the foster kid what is going on. Why was I being moved? Give me time to say goodbye to friends at school
- Stop talking about us like we're not there. I was never a part of the adult conversations about me.
- *Did she have a lot of questions?* I was too overwhelmed for questions.

What was the hardest part of living in foster care?

- Caseworker explained to me at age of nine, in child terms, that I am going to live with someone else.
- I was taken right after school. I didn't get a chance to get my stuff.
- I had to collect stuff while I was being moved.
- I didn't get my blanket, or other stuff that mattered
- A stable caseworker would have been really helpful.
- Seeing a caseworker more often would have helped.

- Advanced warning would have been nice. I moved between houses too quickly without transition time. It was like, “You have 10 minutes to pack and go.”
- It would be nice to tell you how your brother and sister are. You don’t stop to ask at that age, but later you think about it.
- I was locked in JDH at first, and then went home. They took me from my mom and grandmother without a chance to say goodbye.
- It felt like they lie to you, and don’t fill you in more. I would prefer the hard reality without sugar coating it. It is false hope to give you the impression it won’t last long, and then it does.
- Coming back from Redmond, returned to Salem around 5pm, went to DHS office to find out they had no placement for me, so I went to a treatment facility even though I didn’t need it. I stayed there for two months.

When first placed in care, what information were you given?

- Was in “Juvy” before, then they told me would be placed in a foster home. I didn’t like the “two-week blackout period” of my original placement. They listened to my phone calls, limited time to talk, and read all my letters. I wasn’t allowed to leave the house. It felt like I was back in juvenile detention.

Other things that stand out to you?

- The monitoring system was in the living room, adding to the sense of no privacy.
- They were asking about stuff that was none of their business, and would spread the word around (from caseworker to service provider to others).
- Surprised by how many kids said they were not allowed to do ‘that’ at their home. Foster parents should have consequences fitting the behaviors.
- Experienced a difficult rule, such as no cell phone. Later, I was not allowed to charge my phone in my room. People took my phone, and texted from it, to people I didn’t know, and were reading my messages. I was 18, and treated like I was 10 (curfew, early bed time, etc).
- There are some 17 year olds who can handle things that others their age cannot. Treat each child case by case, not all the same. It may seem unfair, but you can explain the way you treat them based on their actions.
- Was in a home then moved to Sheridan, and hated it because the foster mom was a parent, but the dad was only a foster dad. When the foster mom left, the dad had a Christmas with *his* kids. There were cameras everywhere.

Did you get a chance to do sports or other activities you were interested in?

- Not an issue.
- Depends. Each youth in individual level of restrictions, each branch interprets guidelines again, and then each foster home reinterprets it again.
- Three kids in three homes on same street could be living under totally different parameters.

Attachment C: Fostering Hope Parents Council Focus Group

Question: What could prevent placement disruptions?

- Parents having the skills to be parents - parents getting tools to help them such as Healthy Start.
- My example – not knowing what to do, but then kids are sent back to you from your ex. Could have had helped having more supports for me as their mom – need help not reprimands.
- Groups skills and personal healing. Most of us had our own foster experience – I felt respected family by my foster parents as I grew up but many don't
- Foster Parents were my “parents” They saved my life.
- Foster Parents taught me how to manage my behavior and prepared me to deal with my trauma.
- How can you help the whole family? - I felt I could make it if I had support and good communication.
- I needed honest communication
- Don't give false hope – be careful – do what you say.
- Need support – felt I was on my own – too many things to do.
- Foster Parents communicating with us as parents-we know our own kids. My daughter had the wool pulled over their eyes. If they talked to me, I could give them some ideas.
- I needed hope that I could get back home. Kids in foster care need that. Message that I can make it. Need the “how are you doing” rather than just rules. Need to feel part of the family. Say/find good things about me.
- Foster Parents need to communicate with parents – they can work together and decide how to help – I know how she worked and we could prevent blowups. Also have some sense that we parents can make some decision. DHS & foster parents can't decide on their own- it depends on the parents.
- Even those who don't want their kids back- address what is the basis of them not being able to take care of their kids. Much of it is trauma that the parents have experienced and the stress in their lives.
- Parents need more help in knowing how to deal with things
- Parents getting support even a long time after we get our kids back. It can be tough when you haven't lived with your kid for a long time and then they are back.
- Mentors that would give you counseling before and then after you come back home.
- Parent mentors as well.
- It's the relationships that are important.
- Schools need to have advocates for foster kids; an advocate to give them extra attention.
- Counseling is needed. Someone to show them around in the new school, so they feel they fit it. Foster kids having lunch together or some place to meet in the school so they can make new friends.
- Upper classroom “buddy” for new kids coming in. Older kids mentoring younger kids.

Attachment D: BRS/MH Provider Planning Meeting

January 11-12, 2010

Strengths of the Children

- Resiliency
- Savvy, knowing how to get their needs met
- Ability to relate to interested family/relatives
- Care about their families
- Interested in activities that provide natural connections i.e. sports, art, drama, hobbies, etc
- Open to spiritual search; providers are able to build on this
- Have many adults involved in their lives
- Come into care with considerable assessment information to help their providers
- All have personal strengths and interests to be identified and expanded on
- Tolerate our challenges as a system

Unique Needs

Child Focus

- Stability & predictability
- Family connections and meaningful attachments, cultural identity and spiritual roots
- Trust from involved adults
- More joy in their lives
- Personal stories to be validated
- Some are parents themselves – need support with parenting/grieving if their child not with them
- Physical movement
- Organic/neurological/cognitive problems, co-morbidity needs
- Complexity that does not always fit existing MH or BRS service
- Socialization/stable friendships
- Redemption and forgiveness
- Help with behavioral issues, self-harm & sexual acting out
- Support to learn emotional regulation and alternatives to addiction

Educational Needs

- Help with school performance/support of unique learning styles
- IEP information updated and transferred efficiently
- Require a myriad of school programs and specialized interventions

- Foster parents willing to spend the time advocating for their educational needs
- An IEP that focuses on the child; not the school placement

System Design Focus

- Clear communication about what occurs next, same message from all system partners
- Clear understanding of the specific role everyone has that is involved in their life
- Consistent medical/mental health /education supports as they move from place to place
- Mindful and planned transitions to permanent home with preparation for at least 90 days
- System to work hard at understanding and managing child's relationship with family
- Human support during transitions
- Respite and support for their caregivers/foster parents
- 1:1 staffing availability
- Safety issues proactively addressed
- Long & short term mentors
- Need triggers identified and removed from environment
- Need proactive strategies to keep out of detention and from running
- Crisis intervention and immediate in-home supports until more emotionally regulated
- Well-trained staff
- Inclusion of foster parents and natural family in their plan
- Need EBP's matched with child's unique profile
- Need safety/sanctuary created in home environment or integrated with another program
- Planned and crisis respite
- Cultural sensitivity beyond the white middle class
- More recruitment of homes to match youth's culture
- Fluid system that will coordinate all systems across the needs

RECOMMENDATIONS

Child Focus

- Youth is involved and listened to on team
- Follow up with discharged youth to track real outcomes
- Talk to children currently and formerly in the BRS/MH programs for their insights and recommendations
- Eliminate all garbage bags for transferring of belongings
- Help kids find joy in life. More flexibility in support of them pursuing their interests (flexible funding)

- Find a child’s passion/focus and build on this
- Use assessments/evaluations to build on child’s aptitudes
- Explain what an aptitude is, and what this means in the real world
- Offer per to peer support groups and learning opportunities
- Focus on supportive, normative environments, permanent nurturing relationships
- Support current placement and early identification of what is best long-term environment
- Respond to blow up but don’t disrupt placement, Have strategies in place to maintain placements

System Design

- Develop a culture of “Our Kids” thinking amongst stakeholders
- Cross training on what team members roles are and agency mandates
- Quick accessible information between agencies – ROI and information travels w/ child
- Meet as a team with potential foster parent(s) before placement is decided upon so that the foster parents have more information and strategies can be developed.
- Orientation/training for foster parents regarding SOC agencies, family inclusion, Wraparound process
- Take time to do good placement matching based on child’s needs versus contract limits
- Use history from earlier failed placements for front-end prevention, early intervention
- Consider “no eject policy” to foster provider/team creativity in maintaining placement
- Consider 90-day levels more often to promote continuity of care
- Have one person identified to stay with child through all transitions
- Maintain a primary focus on bringing educators/schools to the table
- Consider a specialized education advocate to help with school issues
- Talk to Special Program Directors (DOE Long-term Care & TX) Nancy Latini/Steve Smith
- Look at OR Social Learning Center’s model around home stabilization
- Devote resources to kinship care searching and skill development
- Develop community based support and strategies that support inclusion of “our kids” with police/neighborhoods
- Look at training from adult care re: alternatives to usual emotional escalation
- Look at contract limitations don’t move kids who are doing well without good transition planning
- Incorporate peer training and mentoring of independent skills
- All youth need a plan for independence
- Look at admin system as well as clinical – consider an administrative work group or do a focus group on this part of the system

- Explore buying capacity to create flexible rapid access to safe setting during crisis
- Maintain tight UR practices to retain capacity

Family Inclusion

- Mandate training and support in working with bio family/relatives
- Build hope through family connections start with ideal then less than ideal options
- Prepare and plan for when a child turns 18 & returns to bio family

Provider Focus

- Stable funding for providers and foster parents
- Build in reward for stabilizing child
- Systemic way to manage individualized needs versus workarounds
- Be aware of recent history of multiple changes for provider
- Understand system development is similar to child development

Attachment E: New Solutions Focus Group on Wraparound with Foster Kids

Would you identify any unique needs for children in Child Welfare custody compared to clients living with their biological or adoptive families?

- Working with multiple families – teams are challenged to work with foster families, and biological families (sometimes there are two or more biological families to coordinate)
- Foster placements don't always “match” a child's cultural needs and this can make service planning difficult as the different cultures are integrated and the separate needs that exist in each are dealt with. This is also difficult for the child moving back and forth between two very different cultures, sets of expectations, etc.
- Most Child Welfare cases aren't run as fidelity wrap due to several factors: Case worker time limitations, no steady attachment to plan around, and frequent moves.
- Children often don't have a constant attachment figure. Attachment needs get further exacerbated by multiple moves.
- Foster parents in proctor or treatment foster care programs typically don't want an extra person to contact, they're already getting their needs met through their program case manager.
- Poor relationships between foster families and bio families
- If there isn't a “return to home” plan for the child, they're in a kind of limbo – there's no family pushing the team to make progress. Teams that have a return to home plan are typically more motivated.
- More needs in terms of emergency placements
- Lack of capacity for emergency placements
- Hard to do fidelity wrap when there are so few natural supports, especially for teens.
- Not enough intensive support for ILP type services – some foster parents are just housing teens
- May take longer to get to the first team meeting due to Child Welfare worker schedules.
- More academic struggles – due to moves, instability in school placement and foster parents who are less likely to track and stay on top of school issues than a parent. With kids in foster care there's no single person tracking and holding school and kids accountable for progress and academic success.

How would your workload be different if all your cases were Child Welfare cases?

- Draining – caseloads are balanced now.
- Child Welfare cases are more often in crisis and often more intense.

- Teams are often less committed, again there's no parent propelling things forward, it's hard to make progress.
- Less value in the culture of Child Welfare to having the youth present at team meetings.

If money were not an issue what services would help this group of kids and to decrease moves?

- A Youth Engagement Specialist who could stay connected to the youth through the long haul, despite all their moves, to give hope and encouragement.
- An educational advocate similar to Juvenile Departments – providing in-depth educational assessments, access to exercises and homework that focuses on lagging skills, liaison to each new school to make sure progress continues.
- After-school drop-in center to provide safe and supervised recreation and academic support
- Extra training/workshops for proctor/foster parents to improve their skills in working with higher need kids.
- In-home crisis intervention available with quick access
- Transportation to/from school and appointments – when kids go into respite or shelter their school and therapy appointments are often disrupted.
- Consultation with a psychiatrist who follows them despite their moves and allows for consistent prescribing with a clear historical perspective
- Better coordination with cross-county services
- Program for teen girls
- RESPITE AND CRISIS RESPITE – more access, more capacity
- Shared respite among a pool of homes so that the kids feel comfortable and safe in respite.
- Better planning related to transition from foster care back to home.

Attachment F: New Solutions Regional Meeting— Working with Child Welfare

WHAT WORKS?

- Fostering attachment between child and foster parent; permanency
- Training families in ‘best practice’ mental health interventions, i.e. CPS-develop the skills of foster parent
- Foster parents who ‘mentor’ bio parents
- Long term relationships despite foster home moves, i.e. mentor
- Partner with CW worker-collaborative planning
- Pre-placement visits, etc. to assess ‘match’
- Clear communication up front-youth’s needs, what is wrap, etc. prior to placement
- Volunteer mentor with own foster care experience
- Dual/shared parenting between bio family and foster parent, particularly through transition.
- CPS training/support for bio and foster parents
- Maintaining relationships by foster family providing respite to bio parents
- Coach parents to talk about frustrations, advocate
- Find other natural supports that youth can ‘attach’ to if move frequently or if they have difficulty building relationship with foster parent
- Maintain some level of family connection even if placement not an option, i.e. phone calls, cards, etc.
- Foster family becoming natural supports after child returns to family.
- Value of continual relationships, i.e. therapist, mentor, etc.
- Use SNCD to identify /match youth to a foster home, ‘market’ strengths and realistically talk about needs. Plan supports from the beginning
- Involve youth in decision-making
- Increased peer supports
- Begin planning for ‘optimal’ placement at the same time as crisis placement. Don’t wait.

Attachment G: Declaration of Support and Commitment to Work with MV-WRAP

The following have signed a Declaration of Support for the MV-WRAP proposal to be a demonstration site for the Statewide Children’s Wraparound Initiative and have committed to work with us in developing a model that will serve children better. Actual Declarations of Support with signatures are available upon request.

Agency/Organization	Signature
Cascadia School District, Special Ed. Director	Vikki Mahatty
Catholic Community Services	Stacy Fennell
Central School District 13J	Dr. Joseph Hunter
Christian Center of Salem	Larry Murell
City of Salem – Mayor’s Office	Janet Taylor
Dallas School District, Special Ed. Director	Christy M. Perry
Dayton School District #8	Janelle Beers
Department of Human Services-District 1	Lee Coleman
Department of Human Services-District 3	Mike Williams, Marco Navarrete
Department of Human Services-District 4	John Meade
DHS, District 3 Operations	Erik East
Easter Seals Children’s Therapy Center	Lona O’Dell
Exchange Parenting CT	Jess Armas
Falls City School District	Aaron Hale
Family Lifelines CCS	Abel Valdez
Fostering Hope Parents Council	Various
CCS Fostering Hope, Director	Heiko Junge
Gelco Charitable Foundation	James D. Monaghan
Jefferson School District, Special Ed. Director	Wendi Luby
Linn Co. Mental Health	Ross Swearingen
Life Directions	Lee Rasca-Hidalgo
Linn County Council on Integrated Children and Family Services	Multiple signers
Linn County Department of Health Services; Mental Health Services	Frank Moore
Linn County Health Advisory Board	Anthony Mamaral Wendy Hoffman Carol Ann Keys Kathryn Henderson Adeline Filer Maureen Robb Barbara Thayer Melissa Yates
Linn County Juvenile Court	Judge Dan Murphy

Linn County Juvenile Department Director	Torri Lynn
Marion – Youth Council	Ricky Ruiz
Marion – Youth Council	Kelly
Marion County Board of Commissioners	Janet Carlson Patti Milne Sam Brentano
Marion County CASA	Jeanne Burbank
Marion County Children & Families	Tamra Goetsch
Marion County Children and Families Commission	Randy Franke; Alison Kelley
Marion County District Attorney	Walt Beglau
Marion County Health Advisory Board	Tim Murphy Terri Salstrom Marybeth Thompson Tim Kelly Cherie Robertson-Girod Faye Melius Patrick M. Vance
Marion County Health Department, Division Director	Sandra Stewart
Marion Co. Health Dept., Alcohol & Drug Council	Raymond E. Wilson
Marion County Health Department-Psychiatric Crisis Services; Adult Mental Health; Children’s Behavioral Health; Adolescent Alcohol and Drug	Scott Richards
Marion County Juvenile Department	Chuck Sybrandt
Marion County LADPC	Mark Caillier, Gary Heard, Bonnie Malek
Marion/Polk Community Health Plan	Dr. David Balmer
McKay High School	Cynthia Richardson
McMinnville School District	Travis Laxton
Mid-Valley Behavioral Care Network	Jim Russell
New Perspectives	Tim Markwell
Newberg – Youth Council	Kei Forbis
North Marion, Special Ed. Director	Sharon Lohse
North Santiam	Jeri Harbism
Northgate LLC CCS	Teri Alexander
Northwest Human Services Manager	Paul Logan
OFSN, State Curriculum Director	Kristen N. Anderson
Options Counseling Services	Steve Allan
Oregon Youth Authority	Mike Runyon, Jim Kramer
Pioneer Trust Bank, N.A.	Michael S. Compton
Polk – Youth Council	Launie Forbis
Polk – Youth Council	Malia Forbis
Polk County – Family Advocate	Janet-Dee Tafolla
Polk County Alcohol and Drug Services	Geoff Heatherington
Polk County Board of Commissioners	Mike Propes, Tom Ritchey and

	Ron Dodge
Polk County Commission for Children and Families	Brent DeMoe
Polk County DHS	Mike Williams
Polk County Juvenile Department Director	Trish Reding
Polk County Mental Health Manager	Geoff Heatherington
Professional Mortgage Corporation	David Hafner
Rainbow Family Services	Josh Graves
Salem-Keizer School District, Student Services	Kelly Evans
Salem-Keizer School District, Student Services	Amanda Smith
Sheridan School District	Candace Pelt
Silver Falls School District	Linda Brown
St. Paul School District	Susan FitzGerald
Tillamook County Juvenile Department	Dan Krein
Tillamook County, Board of Commissioners	Mark Labhart Charles J. Hurliman Tim Josi
Tillamook Family Counseling Services	Pamela J. Mabry
Transitional Aged Youth Advocate – YAT	Dominique Buckley
Valley Mental Health	Kathleen Boyle
WESD	Ann O’Connell
WESD	Ben Root
Willamette ESD	Brian Hilsabeck
Willamette ESD – Yamhill Branch	Kevin Carroll
Withnell Motor Company	R.E. Withnell
Yamhill – Youth Council	Jesus Gonzalez
Yamhill County – Family Advocate	Jan Urton
Yamhill County – Family Advocate	Laura Von
Yamhill County – Parent/Advocate	Leslie Brittell
Yamhill County Chemical Dependency Services	Dawn Cottrell
Yamhill County Children and Families Commission	Marilyn Kennelly
Yamhill County Early Childhood Council	Marilyn Kennelly
Yamhill County Family Advocates	Suzanne Thomas, Kerry Zimmerman
Director, Yamhill County Health and Human Services: Developmental Disabilities; Family and Youth Program; Adult Mental Health; Chemical Dependency; Public Health	Chris Johnson
Yamhill County Juvenile Department	Tim Lowen, Representative Olson
Youth Advocate	Jesse Urton

The following BRS and Mental Health Providers have declared support for the Mid-Valley Project Proposal and have committed to work with the project to develop a system that will improve outcomes for the children served in the project.

Agency/Organization	Signature
Albertina Kerr Centers	Gina Brimmer
Boys and Girls Aid	Vera Stoulet
Catholic Community Services	Jim Seymour; Heiko Junge
Christian Community Placement Center	Ray Falgout; Summer Hunter
Chehalem Youth & Family Services	Deborah Cathers-Seymour; Ruth Stokesbary
ChristieCare	Lynne Saxton
Maple Star of Oregon	Robin Donart
Morrison Child and Family Services	Jim MacRae
Options Counseling Service of OR.	Kelli McKnight
Polk Adolescent Day Treatment Center	Larry Tang
Poyama Day Treatment	Hope Shaw
St. Mary's Home for Boys	Francis Maher
Trillium Family Services	Rich Blum
Youth Progress	Don Didier

Wraparound Fidelity Index

version 4.0

Summary Report



MVBCN Wraparound
June 12, 2009

Prepared by
The Wraparound Evaluation and Research Team

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INTRODUCTION

Purpose

The Wraparound Fidelity Index, version 4 (WFI-4) is designed to assess the extent to which both the principles and core activities are being implemented in service delivery, according to the model defined by the National Wraparound Initiative (2004; see www.rtc.pdx.edu/nwi). The purpose of this evaluation is to determine the extent to which the services and supports that are being received by children, youth, and families enrolled in services in *MVBCN Wraparound* adhere to the principles and primary activities of the wraparound process on an individual child, youth, or family basis.

Procedure

The Wraparound Fidelity Index (WFI) is an interview that measures adherence to the principles and primary activities of the wraparound process on an individual child, youth, or family basis. The WFI is completed through brief, confidential telephone or face-to-face interviews with three types of respondents: (1) parents or caregivers, (2) youths (11 years of age or older), and (3) wraparound facilitators. We believe it is important to gain the unique perspectives of these three informants to understand fully how wraparound is being implemented. In addition, a program or evaluation team may wish to gain the perspective of a fourth type of informant: a team member other than the caregiver, youth, or facilitator.

Caregivers, Wraparound facilitators and Team members are asked nearly identical questions on all 10 principles of wraparound; these respondent forms include 40 items – 4 items per wraparound principle. Many youth items do not measure exactly the same components as the Wraparound facilitators and caregivers (e.g., Voice and Choice items on the caregiver and Wraparound facilitator forms ask about *caregiver* involvement while the same Principle on the youth form asks about *youth* involvement). This was done to make the questions more relevant to youth and better capture their motivation. The youth form includes 32 items.

For each item, respondents' answers from the WFI interview are coded as *Yes* (high fidelity), *Somewhat* or *Sometimes* (partial fidelity), or *No* (low fidelity). Responses to items are also scored by the interviewer on a scale from 0 (low fidelity) to 2 (high fidelity). It is important to note that many of the items are reverse-coded. For example, a *Yes* response on a standard item (e.g., "Before your first team meeting, did your wraparound facilitator fully explain how the wraparound process would work?") would be scored a 2, indicating good Wraparound fidelity. However, a *Yes* response to a reverse-coded item (e.g., "Is it difficult to get team members to attend team meetings when they are needed?") would receive a 0. The four item scores for each Principle are summed, resulting in a total Principle score, ranging from 0 (low fidelity) to 8 (high fidelity). As for many scores from the WFI, these Principle scores are

often expressed as a percentage of total possible fidelity (i.e., a Principle score of 7 out of 8 would be presented as 87.5% fidelity).

It is important to note that the information presented in this report is descriptive and any differences noted (e.g., between respondent types or principles) do not necessarily reflect statistical significance. Findings are presented in four ways, starting with broad summaries and then moving to more detailed analyses:

1. **Total Fidelity scores** are presented for each of the three respondent types and **combined fidelity scores** incorporate data from the three respondents for individual families;
2. **Principle scores** are presented for each of the 10 Principles (combining data across the three respondent types);
3. **Principle scores** for each of the four **types of respondents** are then presented for each of the 10 Principles; and
4. **Individual phase scores** are provided for individual respondents.
5. **Relative areas of strengths and areas for improvement** are included in Appendix A.

Interpreting WFI Results

Until recently, WFI scores for a community or site were difficult to interpret because of the lack of external criteria or norms against which to compare aggregate scores. Stakeholders and program administrators could compare scores to those obtained for other sites or to scores achieved by the program in earlier stages of development, but there were no guidelines to what constitutes “good” fidelity. To begin to overcome this barrier, the research team has begun to compile WFI-4 data nationally. Using this information, we are able to present national means and tentative fidelity standards to help you interpret some of the results presented in this report. For preliminary WFI-4 results, see this link from the 20th Annual Research & Training Center proceedings, held in March 2007.

<http://rtckids.fmhi.usf.edu/rtcconference/handouts/pdf/20/Session%2041/bruns.pdf>.

You may also email wrapeval@u.washington.edu to obtain a copy of the presentation.

To read an article about methods for setting fidelity standards for wraparound using previous versions of the WFI, see:

Bruns, E.J., Leverentz-Brady, K.M., & Suter, J.C. (2008). Is it wraparound yet? Setting fidelity standards for the wraparound process. *Journal of Behavioral Health Services and Research*, 35, 240-252.

OVERVIEW GRAPHS

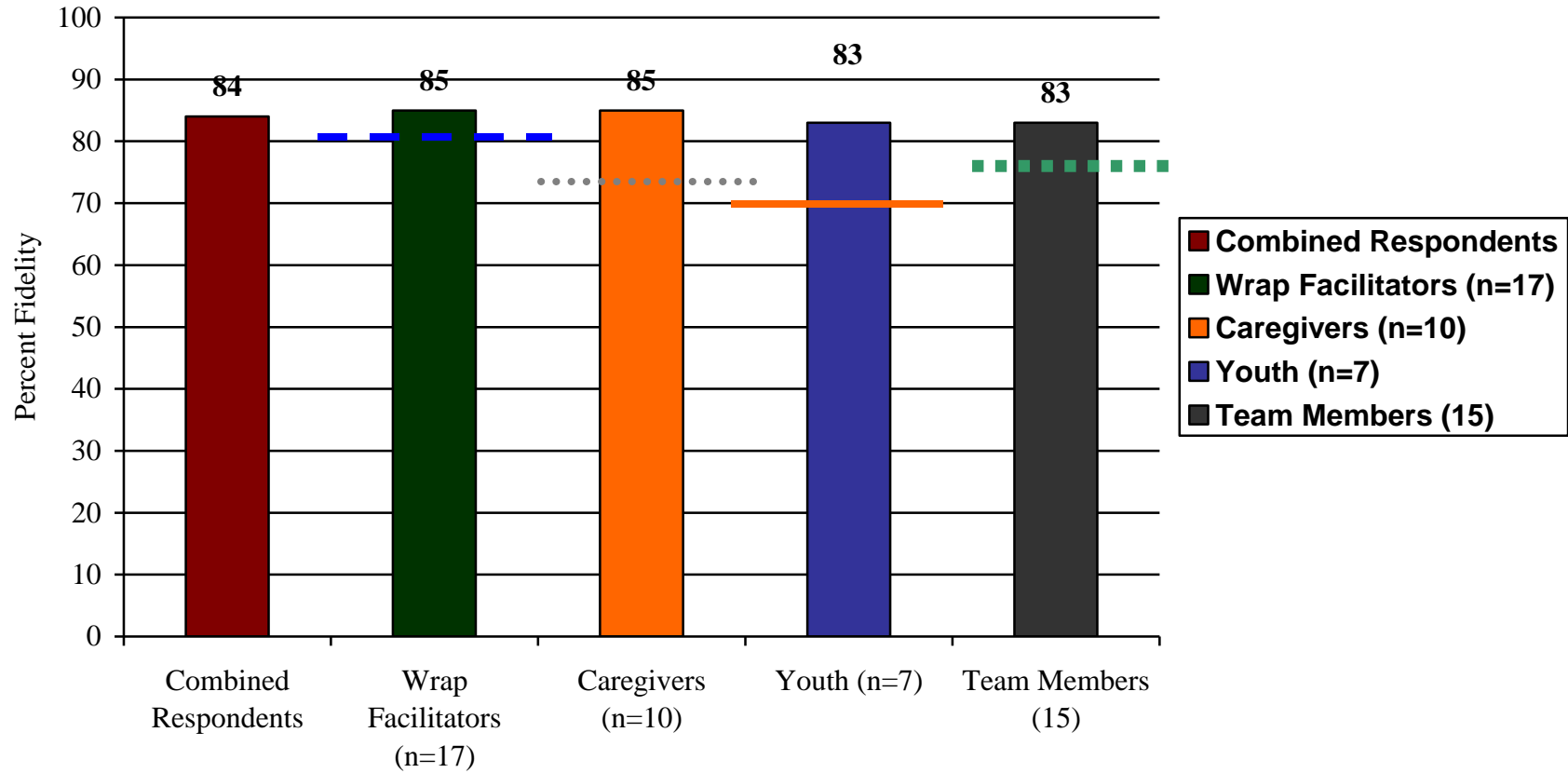
This section includes four graphs that provide a broad overview of the fidelity to the principles of the Wraparound process at in MVBCN Wraparound as measured by the WFI. The goal is to provide your agency with several different ways to examine the interview ratings by Wraparound facilitators, caregivers, team members, and youth.

Percent Wraparound Fidelity for Combined and Individual Respondents

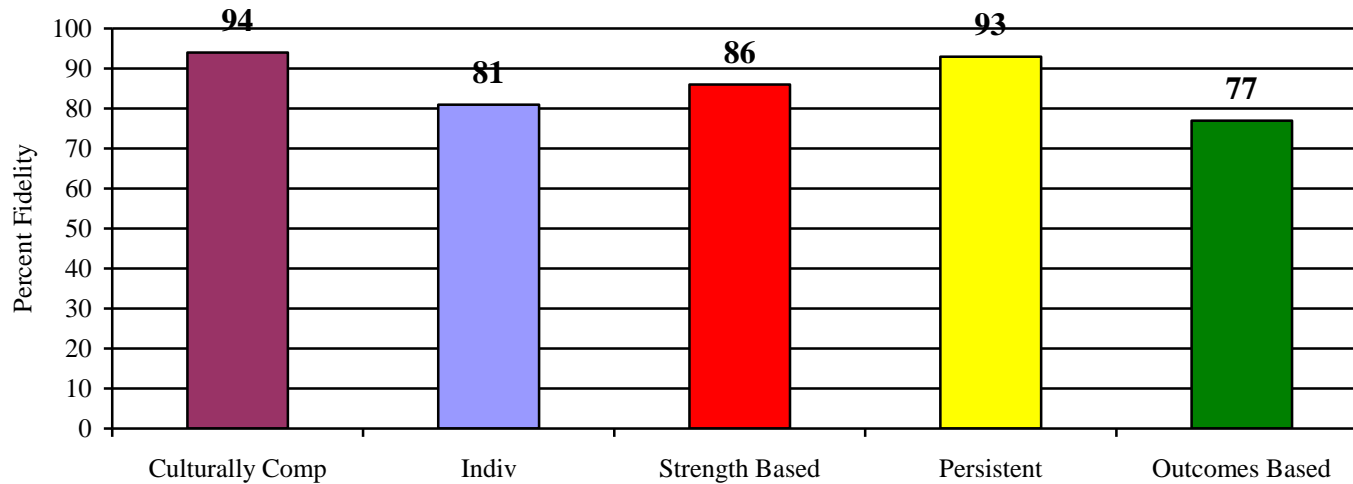
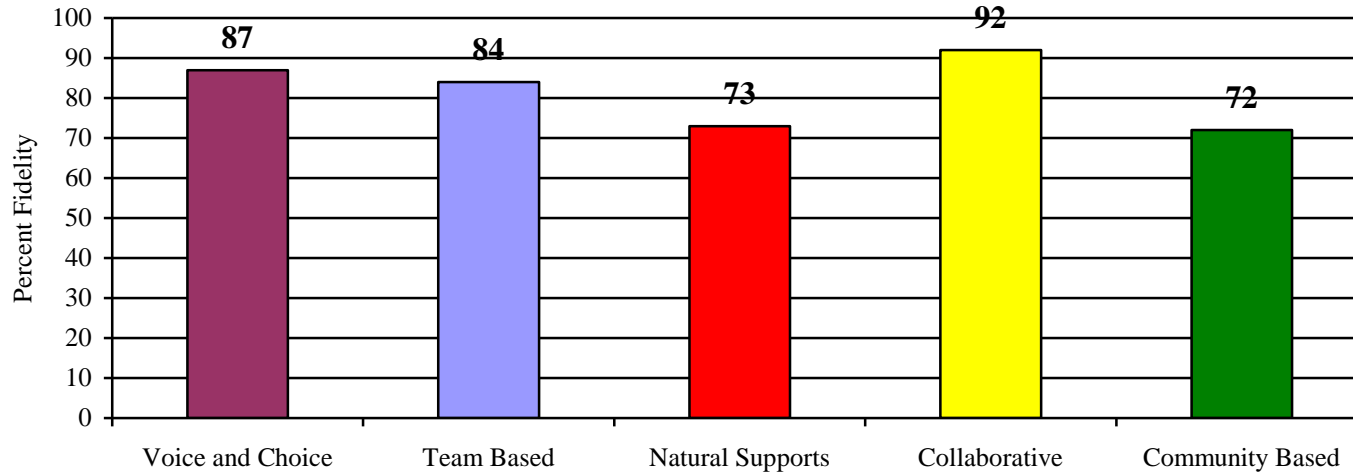
Description. This graph shows *MVBCN Wraparound's* Total Wraparound fidelity scores, expressed as a percent¹ for each of the respondents. These scores reflect broad summaries of all the collected interview ratings and are useful when you are interested in assessing overall fidelity. The *combined* Total Fidelity score is the average WFI rating for 17 families on all 10 principles. The *individual* respondent Total Fidelity scores are the average WFI ratings on all 10 principles and 4 phases for each respondent.

¹ One way of examining Wraparound fidelity is to convert total or Principle scores to percentage scores. Thus, for Total Fidelity scores, 100% fidelity equals the maximum possible score of 80 for caregivers and Wraparound facilitators (40 items on a 0-2 scale) or 64 for youth (32 items on a 0-2 scale). For individual Principle scores, 100% fidelity equals the maximum possible score of 8 (4 items on a 0-2 scale).

Percent Wraparound Fidelity for Combined and Individual Respondents



Combined Percentages on Each Principle for all 17 Families



*This figure can be used to compare WFI fidelity scores for different domains of the wraparound process. These overall scores reflect the combination of the four respondents' scores, which results in a single percentage on each Principle. In the last section of these results, you can see the individual item scores in each principle that was used to derive these scores by principle.

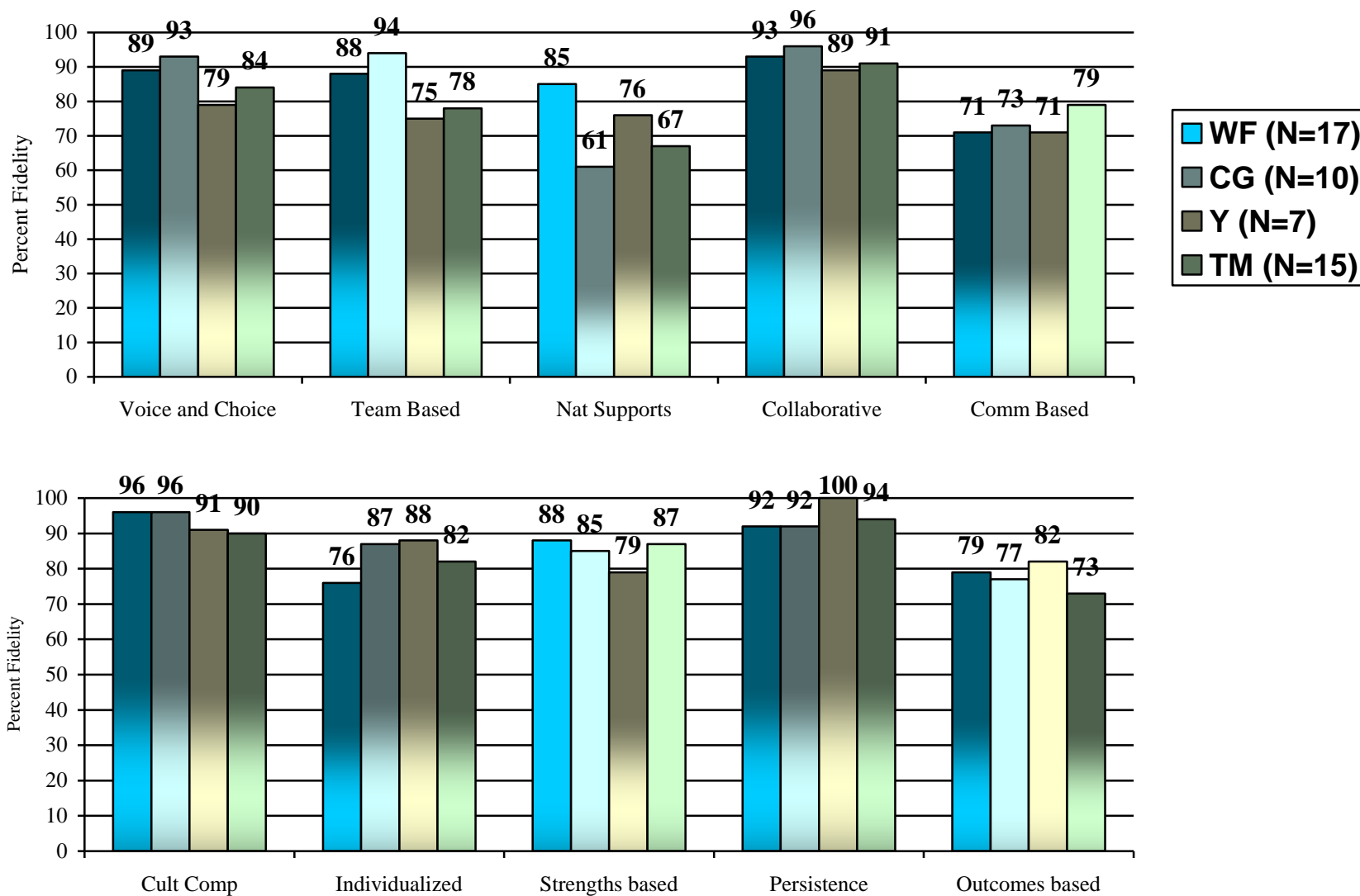
Comparison of Wraparound facilitator, Caregiver, and Youth Principle Percentages for Seventeen Total Families

Description. What the earlier graphs do not allow you to do is compare responses from the three types of respondents. The following graphs depict the 17 total families comparing respondents on each Principle.

For more comparisons to the preliminary WFI-4 data, please see:

<http://rtckids.fmhi.usf.edu/rtcconference/handouts/pdf/20/Session%2041/bruns.pdf>.

Comparison of All Respondents for Seventeen Families by Principle

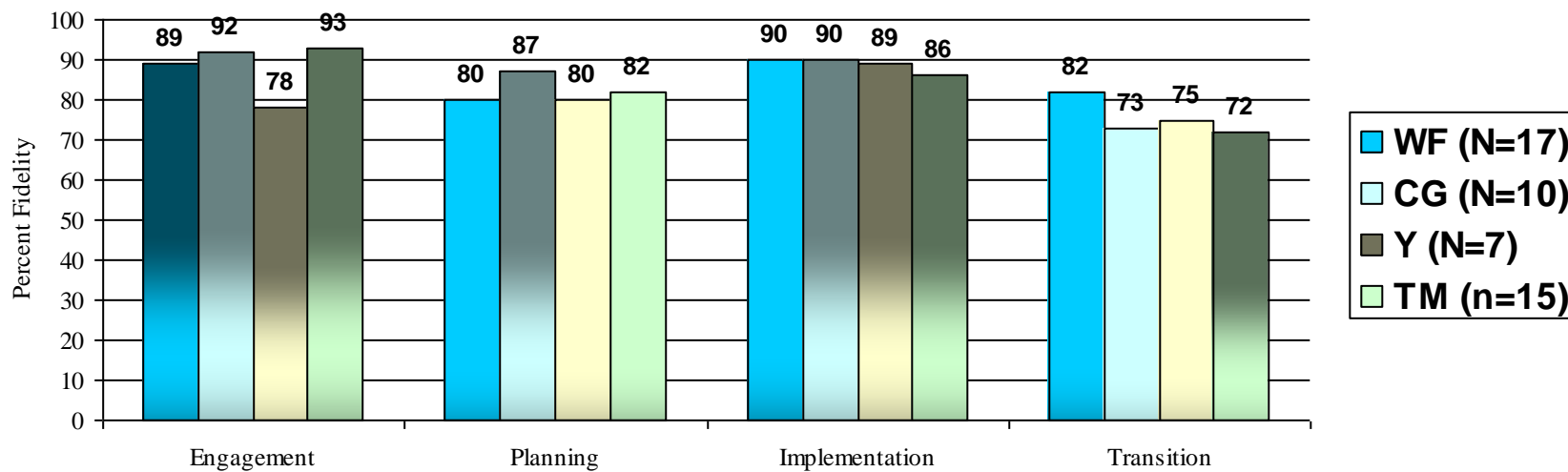


Comparison of All Respondents for Seventeen Total Families by Principle with National Means

	WF		CG		Youth		TM	
Principle	MVBCN Wraparound N=17	National Means	MVBCN Wraparound N=10	National Means	MVBCN Wraparound N=7	National Means	MVBCN Wraparound N=15	National Means
1 – Family Voice & Choice	89	87	92	82	79	78	84	n/a
2 – Team Based	88	79	94	71	75	59	78	n/a
3 – Natural Supports	85	68	61	60	76	71	67	n/a
4 – Collaboration	92	91	96	84	89	75	91	n/a
5 – Community Based	71	76	73	68	71	69	79	n/a
6 – Culturally Competent	96	94	96	90	91	89	90	n/a
7 – Individualized	76	76	87	63	88	68	82	n/a
8 – Strength Based	88	89	85	82	79	78	87	n/a
9 – Persistence	92	86	92	80	100	83	94	n/a
10 – Outcomes Based	79	77	77	63	82	60	73	n/a

*National Means have not been determined for TM principles

Comparison of All Four Respondents for Seventeen Total Wraparound Families by Phase



Comparison of All Four Respondents for Seventeen Total Families by Phase with National Means

Phase	WF n=17		CG n=10		Youth n=7		TM n=15	
	MVBCN Wrap	National Means	MVBCN Wrap	National Means	MVBCN Wrap	National Means	MVBCN Wrap	National Means
1 – Engagement	89	85	92	75	78	65	93	80
2 – Planning	80	82	87	74	80	71	82	77
3 – Implementation	90	85	90	79	89	81	86	82
4 – Transition	82	75	73	65	75	66	72	67

APPENDIX A

RELATIVE STRENGTHS RELATIVE AREAS FOR IMPROVEMENT

Relative Strengths

Showing items .4 SD above the national mean.

Item (FROM CG FORM)	Nat. Mean	Your Score
1.2 Before your 1st team meeting, did your wa facil fully explain the wa process and the choices you could make?	1.68	2
1.3 At beginning of wa process, did you have a chance to tell wa facil what things have worked in the past?	1.75	2
1.4 Did you select the people who would be on your wa team?	.86	1.89
2.2 Did the team develop any kind of written statement about what it is working on with your child and family? *and* Can you describe what your team mission says?	1.56	1.89
2.3 Does your wa plan include mostly professional services?	.61	1.20
2.7 Does your team brainstorm many strategies to address your family's needs before selecting one?	1.73	2
2.9 Do you feel confidant that, in crisis your team can keep your child in the community?	1.5	1.78
2.11 During planning process, did team make enough time to understand values? *and* Is your wa plan in tune w/ family's values?	1.73	2
3.5 Do the members of your team hold each another responsible for doing their part?	1.7	2
3.7 Does your team come up w/ new ideas? *and* Does your team come w/ ideas when something's not working?	1.74	2
3.10 Do members of your team always use language you can understand?	1.93	2
3.11 Does your team create a positive atmosphere around successes and accomplishments at each team meeting?	1.86	2
3.12 Does your team go out of its way to make sure all members present ideas and participate in decisions?	1.67	2
3.13 Do you think your wa process could be discontinued before you're ready?	1.35	1.71
3.14 Do all the members of your team demonstrate respect for you and your family?	1.88	2
4.3 Has the wa process helped your child to solve their own problems?	1.3	2
4.4 Has your team helped you and your child prepare for major transitions?	1.35	1.71
4.5 After formal wa ends, do you think the process will be able to be 're-started' if you need it?	1.61	2

Relative Areas for Improvement

Showing items .4 SD below the national mean.

Item (FROM CG FORM)	Nat. Mean	Your Score
3.3 Does your wa team get your child involved w/ activities they like and do well?	1.20	.9
4.2 Has the wraparound process helped your youth develop friendships with other youth who will have a positive influence on her or him?	1.20	.78

Attachment I: 2008 MVBCN Infrastructure Survey Report and Recommendations

August 2008
(Questions 1 – 10)

1. *The structure and decision making process of the Care Coordination Committee values and elicits the expertise of all members and creates an atmosphere of safety & friendliness for families. The Committee addresses barriers to family participation.*

All five Community Care Coordination Committees (CCCC) thought this question was difficult to score since it included two distinctly different questions. Committees valued the expertise of all members but there was no concrete evidence that an atmosphere of safety and friendliness had been created for families or barriers to participation were identified or addressed.

Recommendation: Strive for 51% family membership on the CCCC and develop an exit survey for families to complete after their child's needs are presented to the Community Care Coordination Committee.

2. *The cultural diversity of the community is represented in the membership of the Care Coordination Committee.*
3. *A diverse group of family members are active and respected members of the Care Coordination Committee.*

These two questions which address committee composition regarding cultural diversity and diverse family membership had the lowest of all survey scores.

Recommendation: Committees would benefit from the inclusion of tribal and faith-based representatives as well as members who have experience with generational poverty. Family participation needs to include youth, fathers, grandparents, and foster parents.

4 *The Care Coordination Committee monitors the implementation of services and develops plans to improve local capacity to support children and families.*

All five Committees felt they did a good job monitoring the implementation of services. Marion County thought they could do a better job of improving local capacity if updates were provided on the children approved for a higher level of care.

Recommendation: Updates regarding a child/youth's progress and needs would assist the Committees in understanding what worked; and enhance planning; and improve local capacity.

5. *The people who attend collaborative meetings are leaders who influence policy, make decisions and commit resources from their organization to support the goals and work of the Care Coordination Committee.*
6. *The Care Coordination Committee understands funding sources, restrictions and allocations across organizations.*
7. *The Care Coordination committee monitors overall cost of services and works together to contain costs and manage risk.*

These questions on influencing policy, committee resources, understanding funding issues across organizations and monitoring costs had the highest scores.

Committees felt members at the table had an adequate understanding of the complexity of funding or knew who to go to for more information. All committees reviewed BCN financial reports on a regular basis. Some members felt the words; “monitor costs and manage risk” were overstated suggesting a board of directors function beyond their committee’s scope.

8. *Partner organizations within the MVBCN region practice collaboration and partnership by providing cross-organization training, education and support for local implementation of wraparound.*

This question measures the practice level of collaboration and cross training among partner agencies. In general, committees scored themselves high but commenced robust conversations on how it does not happen often on the committee level and certainly not with line staff. Smaller communities seemed correlated with less turn over and need for repeated training. Schools through out BCN region and DHS in Marion County were identified as the partners with the greatest need for ongoing cross training.

Recommendation: Develop a communication plan involving a resource sharing training to include committee members and direct service staff across agencies. Create a more intensified version for schools throughout the region and DHS in Marion County.

9. *The Care Coordination Committee understands the need for and assists with the development of, community resources to provide natural support for local implementation of wraparound.*

Committees struggled to understand this question and coped by scoring them either high or in the middle. Comments included concerns about whether this task was bigger than the group; where would the funding emerge from; perhaps a better definition of what this question implies would clarify a direction.

Recommendation: Discuss the definition at EOC with the expertise of family advocates; develop a list of clear outcomes for local Committees to address.

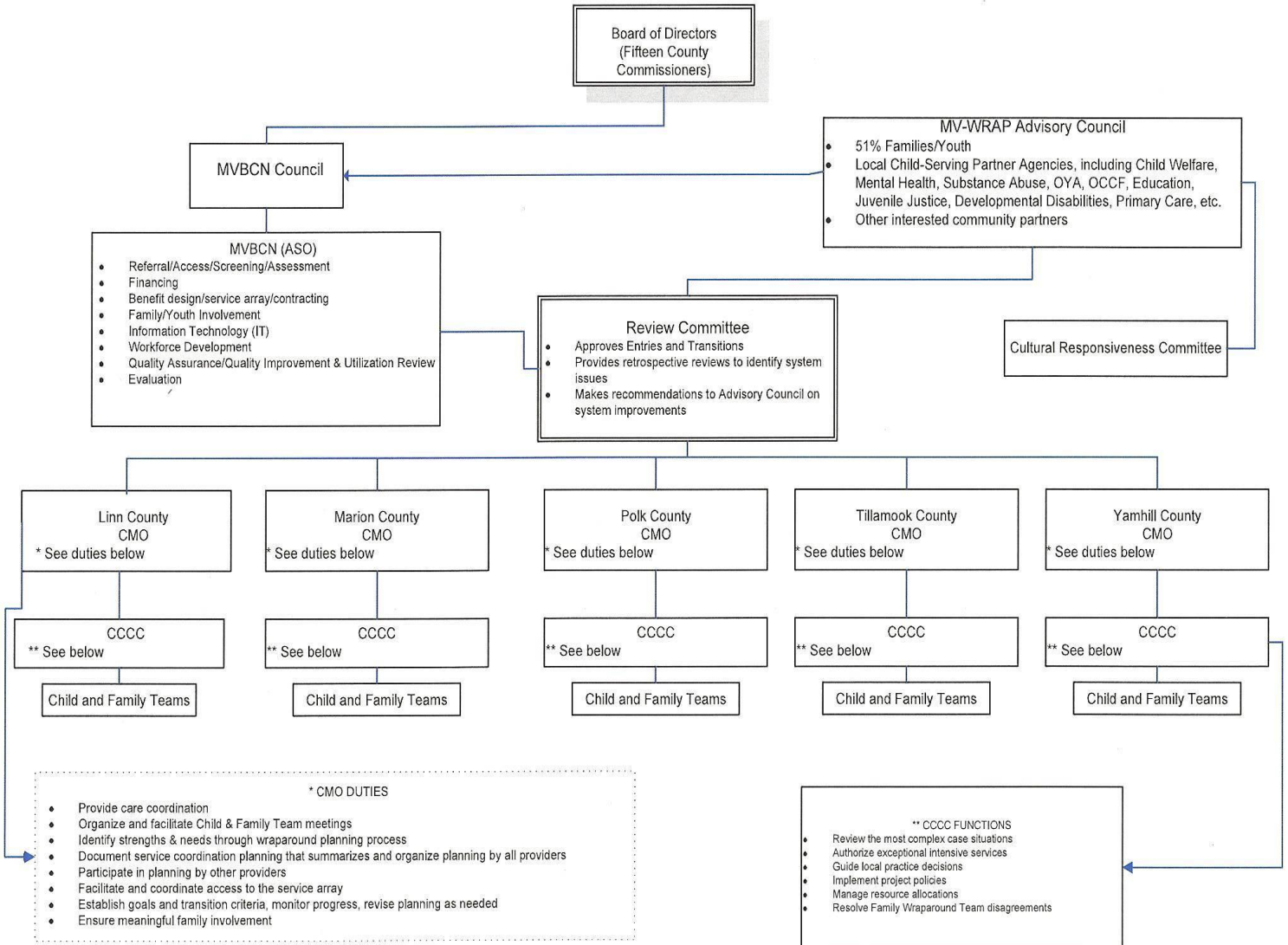
10. *Providers of services and supports are continually educated about wraparound philosophy and its implications for the design and delivery of services and supports.*

Most Committees were confused on the difference between this question and # 8. One group suggested the philosophy and its implications for design and delivery often got lost in the discussion of a child's complex needs.

Recommendation: Post a list of the 10 Principles of Wraparound to be displayed at all Committee meetings. Ensure presentations always include a review of a child/family's strengths.

Attachment J: Project Governance Structure

Project Governance Structure



Attachment K: National Standards on Culturally and Linguistically Appropriate Services (CLAS)

Standard 1

Health care organizations should ensure that patients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 2

Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3

Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Standard 4

Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5

Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6

Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7

Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Standard 8

Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9

Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Standard 10

Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Standard 11

Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12

Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Standard 13

Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

Standard 14

Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Attachment L: Population/Diversity Profile of Region

MV-WRAP Regional Demographics (data from 2008)

Location -> Demographic ↓	OREGON	Linn (U)	Marion (U)	Polk (U)	Tillamook (R)	Yamhill (U)	MV-WRAP
% change in population from 2000 - 2008	10.8%	11.9%	10.5%	23.6%	2.7%	15.5%	12.6%
Population Size	3,790,600	115,348	314,606	77,074	24,927	98,168	630,123 (16.6% of OR's population)
•Under 5 years old	242,564 (6.4%)	7,613 (6.6%)	24,539 (7.8%)	4,547 (5.9%)	1,396 (5.6%)	6,479 (6.6%)	44,574 (7.1%) (18.4% of OR)
•5-18 years old	867,924 (22.9%)	27,222 (23.6%)	83,685 (26.6%)	16,648 (21.6%)	5,010 (20.1%)	23,364 (23.8%)	155,929 (24.7%) (18.4% of OR)
•Female	1,906,400 (50.3%)	58,366 (50.6%)	155,415 (49.4%)	39,770 (51.6%)	12,439 (49.9%)	48,299 (49.2%)	314,289 (49.9%) (16.5% of OR)
•Male	1,883,660 (49.7%)	56,982 (49.4%)	159,191 (50.6%)	37,304 (48.4%)	12,488 (50.1%)	49,869 (50.8%)	315,834 (50.1%) (16.8% of OR)
•White	3,414,844 (90.1%)	109,235 (94.7%)	290,696 (92.4%)	71,756 (93.1%)	23,681 (95.0%)	92,278 (94.0%)	566,346 (89.9%) (16.6% of OR)
•Black	75,801 (2.0%)	692 (0.6%)	4,090 (1.3%)	617 (0.8%)	125 (0.5%)	1,080 (1.1%)	6,604 (1.0%) (8.7% of OR)
•American Indian/Alaska Native	53,061 (1.4%)	1,615 (1.4%)	5,034 (1.6%)	1,464 (1.9%)	349 (1.4%)	1,473 (1.5%)	9935 (1.6%) (18.7% of OR)
•Asian	136,442 (3.6%)	1,153 (1.0%)	6,292 (2.0%)	1,310 (1.7%)	224 (0.9%)	1,276 (1.3%)	10,255 (1.6%) (7.5% of OR)

Location -> Demographic ↓	OREGO N	Linn (U)	Marion (U)	Polk (U)	Tillamoo k (R)	Yamhill (U)	MV- WRAP
•Native Hawaiian/Pacific Islander	11,370 (0.3%)	231 (0.2%)	1,258 (0.4%)	231 (0.3%)	50 (0.2%)	98 (0.1%)	1,868 (0.3%) (16.4% of OR)
•Multi-racial	94,752 (2.5%)	2,422 (2.1%)	6,921 (2.2%)	1,773 (2.3%)	499 (2.0%)	1,963 (2.0%)	13,578 (2.2%) (14.3% of OR)
•Latino/Hispanic	416,907 (11.0%)	7,267 (6.3%)	71,730 (22.8%)	8,864 (11.5 %)	207 (8.3%)	13,940 (14.2%)	102,008 (16.2%) (24.5% of OR)
•White – not Latino/Hispanic	3,032,04 8 (80.0%)	102,54 4 (88.9 %)	223,056 (70.9%)	63,278 (82.1 %)	21,736 (87.2%)	79,025 (80.5%)	489,639 (77.7%) (16.1% of OR)
Non-English speaking home	458,597 (12.1%)	6,806 (5.9%)	61,348 (19.5%)	7,707 (10.0 %)	1,570 (6.3%)	10,995 (11.2%)	88,426 (14.0%) (19.3% of OR)
People below federal poverty level	492,708 (13.0%)	15,918 (13.8 %)	47,820 (15.2%)	8,324 (10.8 %)	3,440 (13.8%)	11,486 (11.7%)	86,988 (13.8%) (17.7% of OR)
People from 100%- 200% federal poverty level (est.)	1,970,83 1 (70.0%)	84,781 (73.5 %)	251,370 (79.9%)	53,258 (69.1 %)	20,340 (81.6%)	61,748 (62.9%)	471,497 (74.8%) (23.9% of OR)
People over 200% federal poverty level (est.)	1,326,52 1 (17.0%)	14,649 (12.7 %)	15,416 (4.9%)	15,492 (20.9 %)	1,147 (4.6%)	24,934 (25.4%)	71,638 (11.4%) (5.4% of OR)

Sources:

“Linn County QuickFacts from the US Census Bureau,”

<http://quickfacts.census.gov/qfd/states/41/41043.html>; retrieved 2/20/2010; “Marion County QuickFacts from the US Census Bureau,” <http://quickfacts.census.gov/qfd/states/41/41047.html>; retrieved 2/20/2010;

“Northwest Area Foundation,”

<http://www.indicators.nwaf.org/DrawRegion.aspx?Action=DrawRankings&RegionID=41000&IndicatorID=100011>; retrieved 2/20/2010; “Oregon Progress Board Oregon Benchmarks,”

<http://www.oregon.gov/DAS/OPB/obm.shtml>; retrieved 2/20/2010; “Polk County QuickFacts from the US Census Bureau,” <http://quickfacts.census.gov/qfd/states/41/41053.html>; retrieved 2/20/2010 “Tillamook County QuickFacts from the US Census Bureau,” <http://quickfacts.census.gov/qfd/states/41/41057.html>; retrieved 2/20/2010

“Yamhill County QuickFacts from the US Census Bureau,”

<http://quickfacts.census.gov/qfd/states/41/41071.html>;

Attachment M: Draft - Best Practice Care for Children with Attachment Disorders

January 2010

Introductory Questions/Decisions:

1. Will it be useful for therapist personally to form a relationship with the child?
 - How many relationships is the child already trying to manage?
 - How is that going?
2. What would the purpose of individual therapy be? Is child ready and able to do these?
 - Has trauma history and is ready to openly address
 - Skill development
 - Capacity for Insight
3. Look at lagging skills (Collaborative Problem Solving, relationship skills) and decide who (therapist or parents) best to address with child
4. Thorough assessment of parents: resources, structure of home, beliefs about child behavior
5. Standardized assessment tools?
 - Attachment Disorder Assessment Scale, Revised

Child/Youth:

1. Continually evaluate need and effectiveness of individual therapy
2. Look at how many activities child can handle at a given point in time
 - Some need MORE, some need LESS
3. Long-term goals: get kids in activities based on strengths
 - Hopefully some team-based
 - Something helping others: teaching younger kids, knitting hats for kids in Africa
4. Lifebook
 - Does child have one already?
 - Is it good enough or worth reworking?
5. Family Genogram of birth and adoptive families
6. Recognize complicated feelings about:
 - Birth, adoptive, and/or former caregiver homes
 - Also birth siblings
7. Balance accepting past (identify) and connecting with current family

Parents/Caregivers:

1. Therapist **MUST FORM A STRONG RELATIONSHIP** with the Caregivers!!!
2. Address immediate safety needs
3. Differentiate immediate safety needs vs. very unpleasant behavior (hitting younger children vs. urinating in the corner)
4. Have a session right away, without child present, for caregiver(s) to vent

- LISTEN; validate their experience; empathize with hurts, struggles, and how much tried to give child; develop trust; goal is for therapist to understand and connect with the caregiver(s)
 - Address level of burnout and normalize
 - Acknowledge that will be asking caregiver to change to meet needs of child; this may seem counterintuitive to caregiver
 - Give hope that therapist has seen these tools be effective and create change in other kids
 - Reassure parent is not “bad” because didn’t know another way to parent
 - Empathize, cheerlead, encourage things can be different, even though it is hard work
5. Address blame/shame aimed at parent, internal in parent and external from others around the parent (if you would only spank her more, she would behave)
 6. Identify why need empathy for child in order for behavior to change
 7. Assess caregiver attachment style and capacity (Inner Working Model of the Child)
 8. Determine parent readiness to do attachment activities
 9. Develop Agreement to meet w/caregivers without child (often spend 50% or more of time alone with caregivers)
 - The more the parent struggles with behaviors and understanding why child behaving this way, the more time therapist needs to spend alone with caregivers
 - Goal to help parents see needs
 - Struggle for caregivers not to feel “blamed” when therapist asking them to come in without the child
 - Caregivers vacillate between blaming self vs. blaming child
 - Cover theory, understand child’s behaviors, air frustrations, problem-solve, develop pro-active strategies
 10. Develop a shared definition of issues
Education/support are on-going, and part of every session
 11. Recognize child can’t change all behaviors at once, prioritize concerns (what to let go for now and return to later)
 12. Develop a good/helpful natural support system
 - ORPARC, community resources, OSFN
 13. Revising ideas of “successful treatment” and adjusting expectations
 14. Set up respite right away

Cautions:

1. Adoptive/foster: often come in shaming/blaming child; be careful not to encourage
2. Birth families: be careful not to shame/blame parent
3. Need strategy for how to give foster parents information
4. Need to develop positive relationship w/Caseworker and determine what info to share
5. May need to do education with others in child’s life: Caseworker, School

6. Need plan for Managing Behaviors and developing Calming Techniques
7. Every session starts where caregiver is; therapist needs to not have agenda
8. Grandparents issues to consider: grief/loss; can't see birth parents (their children) parenting again
9. Watch for ingrained beliefs, example: we are doing better than child's own parents
10. Watch for caregiver HUGE emotional investment in child: can be positive and help caregivers withstand significant behaviors of child or can prevent caregivers from seeing level of need and responding appropriately to that level

Developed by staff from MVBCN region in a work group addressing best practice processes for children with attachment disorders. Staff include Christine Hall, Gwen Kraft, Nicole Galberth, Kara King, Jan Cain, Barb Smith, Christina Anderson