Annual Report

Evaluation 2010 – 2011

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Executive Summary

Approximately one in five children struggles with mental illness, impacting almost every family in America. The Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that 4.5 to 6.3 million children and youth are living with serious mental health challenges in the United States. About two-thirds of these young people do not receive the specialty services and supports they need. In many communities, services for youth with mental health challenges are unavailable, unaffordable, or may not be sufficient to address their needs, leaving these youth at risk for difficulties in school and/or the community.

To meet the needs of these children and families effectively and efficiently, child-serving social systems must work collaboratively to provide quality, comprehensive services. In Wayne County, Connections has been established to guarantee cooperation between these systems, the community, and children and families.

This report describes the evaluations of major Connections activities which took place during Fiscal Year 2010. Findings are arranged in chapters for clarity. Chapter 1 describes in detail the origin, philosophy, and structure of Connections. Chapter 2 highlights Connections' "Special Projects", including a major initiative in 2010- the High-End User project. Chapter 3 focuses on youth involvement in Connections, particularly the role of Lead Youth Advocates. Chapters 4-7 present findings of individual evaluations of practice models utilized throughout Wayne County, including training initiatives, demonstration projects, and service models that are currently in full implementation.

Findings reported in this document do not cover all activities that took place under the umbrella of Connections during FY10, yet represent a number of key efforts that have been put in place to serve children and families in Wayne County.

Summary of Key Findings:

Collaborative Efforts

- Guided by a Systems of Care approach, Connections has grown to include a collaborative partnership between all child-serving agencies within Wayne County.
- Youth and family involvement is strong, with representatives active in all levels of Connections governance.
- Lead youth advocates were hired at partner agencies and are responsible for organizing youth in the community, providing oversight for all Connections activities, and informing the strategic direction of the system of care.

Special Projects

- Connections Special Projects are a successful way for the collaborative to examine children involved in multiple systems and facilitate systems change.
- The School-Based Special Project identified a number of barriers to access that exist at both the consumer and system specific level, including a lack of familiarity with available resources and a lack of understanding of serious emotional disturbance (SED) or other behavioral challenges.
- Families were satisfied with the assistance navigating the various systems that was provided by Connections.
- The High-End User Special project analyzed children with the most intensive and expensive needs across three partnering systems. $10,157,121 had been spent by the systems over 4 years to provide services to these 119 children.
- The High-End User Special Project confirmed that consumers with the most complex needs are usually involved in multiple systems, and children in this population spent an average of 4.5 years in out-of home placement.
- 95% of children analyzed in the High-End User Project had history of trauma, most having experienced more than one type of trauma.

Children's Initiatives

- Six provider agencies and 77 youth and families participated in the Adolescent Multi-Family Groups initiative, which targets youth with mood disorders and their families. Based on challenges faced with group formation and retention, the model has been adapted to better meet the needs of the population.
- Therapists continue to undergo the training and certification process to deliver Parent Management Training- Oregon services. Fourteen therapists were certified in FY11 at 11 provider agencies, and provided services to over 135 families.
- Seven provider agencies utilized Trauma-Focused Cognitive Behavior Therapy during FY2010.
- Thirteen transition-age youth were enrolled in the Cornerstone program in FY11. Participation in group sessions has increased significantly, and clients who are engaged and responsive have built strong social relationships.
- Enrollment in Infant Mental Health programs has increased over time, and approximately 60% of infants improved in functioning.
- Results from a self-report fidelity survey indicate that caregivers feel their experience in the process is in agreement with the overall philosophy of Wraparound.
- Over 40% of Wraparound experienced improvement in functioning, as measured by an improvement on one or more CAFAS indicators, after an average of ten months of services.
- Among youth who reported having engaged in unsafe behaviors prior to Wraparound, 87.5% reduced the number of dangerous or reckless actions they engaged in, 90% reduced the number of times they physically hurt themselves on purpose, and 71.4% reduced the times they physically hurt others on purpose.

Chapter 1: Background

Connections History

Connections evolved out of the desire of system leaders to address the need for better integration of services for children and their family in Wayne County. Although children often received services at an array of social service agencies, there was minimal coordination of care between the systems. Efforts began in the early 1990s, and in 2000 a Memorandum of Understanding (MOU) was signed by the Third Judicial Circuit Court, the Michigan Department of Human Services, and Wayne County Department of Child and Family Services. This document provided a written agreement between the systems to work together to better integrate services for children. At that time, presiding Chief Judge Mary Beth Kelly incorporated the mental health system into the partnership to address children and youth with behavioral health needs. The new partnership progressed into Wayne County Systems of Care in 2007, when it secured state mental health block grant funds. In 2008, the MOU was expanded to include partners in the Educational System. The collaborative continues to grow and works together to build a structure that provides a cross-system continuum of care for children and their families.

Systems of Care Approach

Connections utilizes the Systems of Care (SOC) approach to serve children in Wayne County. Systems of Care is not a program, but rather an approach to services that recognizes the importance of family, school, community, and seeks to promote the full potential of every child and youth by addressing their physical, emotional, intellectual, cultural, and social needs. First published in 1986 by Stroul and Friedman[1], the definition of a system of care was stated as being a "comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the changing needs of children and their families".

Coordination between systems who serve children and families is necessary to ensure the best possible outcomes for children and families. Systems of Care shapes organizational policy and regulations, blends funding, and improves the quality of services and supports through training and evaluation.

SAMHSA defines a SOC as "A coordinated network of community-based services and supports that are organized to meet the

[1] Stroul, B. & Friedman, R. (1986). A system of care for children and youth with severe emotional disturbances. Washington, D.C.: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

challenges of children and youth with serious mental health needs and their families. Families and youth work in partnership with public and private organizations to design mental health services and supports that are effective, that build on strengths of individuals, and that address each person's cultural and linguistic needs. A system of care helps children, youth, and families function better at home, in school, in the community and throughout life."

Values and Principles

Connections integrates the values and principles of a system of care into every level of governance and implementation.

Values[2]

1. Family Driven and Youth Guided: The needs of the child and family determine the types and mix of supports provided.
2. Community Based: The locus of services as well as system management rests within a supportive, adaptive infrastructure of structures, processes, and relationships.
3. Culturally and Linguistically Competent: Agencies, programs and services provided reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve. This facilitates access to and utilization of appropriate service reports and eliminates disparities in care.

Principles[3]

1. A comprehensive array of services and supports
2. Individualized services to meet the unique needs and potential guided by an individualized service plan
3. Services in the least restrictive environment
4. Family participation in ALL aspects of planning, service delivery, and evaluation
5. Integrated services with coordinated planning across the child-serving systems
6. Case Management or service coordination with linkage between child-serving agencies and programs
7. Prevention, early identification, and intervention promoted by Connections to enhance positive outcomes
8. Smooth transitions among agencies, providers, and to the adult service system
9. Promote human rights protection and advocacy
10. Nondiscrimination in access to services

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[2] Stroul, B., Blau, G. and Friedman, R. (2010). *Issue Brief: Updating the System of care Concept and Philosophy.* Washington DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

[3] Pires, S. (Spring 2002). *Building Systems of Care: A Primer.* Washington DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

Outcomes

Systems of Care have been implemented throughout the United States and have seen favorable outcomes for children and their families. The national evaluation[4] of all grant-funded SOC communities found the following outcomes:

- Improved school attendance
- Improved school achievement
- Mental health improvement
- Fewer days in out-of-home placements, including hospitals and juvenile detention
- Financial savings due to effective community-based service delivery

Connections Structure

The system of care philosophy has developed into a framework for Connections that involves three levels. At the consumer level, practice models include all the support, services, and resources that are delivered directly to families. The next level, community collaborative, includes all partner projects and community collaboration efforts. This level ensures and recognizes the role of all community partners in the delivery of children's services. The final level, governance, involves cross-system leadership who plan Connections initiatives and make decisions. The framework can be found on Page 9.

Governance

All system partners are represented on each committee, and all members work to uphold the values and principles of systems of care.

1. Cross-Systems Management Team: Members of this subcommittee make strategic decisions and inform policy regarding Connections. The team includes individuals with decision making authority within their home system.
2. Children's Systems Transformation Work Group: This subcommittee focuses on Evidence based/Promising Practices of Wayne County Children's Initiatives that ensures the System of Care principle of a "flexible array of services & supports".
3. Evaluation Subcommittee: Members of this subcommittee determine evaluation criteria, work to standardize assessments and forms across Wayne County, review evaluation findings, and provide input and recommendations.
4. Development Subcommittee: This subcommittee works to identify funding sources for Connections and its stakeholders, as well as endorse cross-system collaboration that fosters the

[4] Substance Abuse and Mental Health Services Administration (SAMHSA) (2008). *National Evaluation of the Comprehensive Community Mental Health Services for Children and their Families Program*. Washington DC.

acquisition of funding, resources, technical assistance, and capacity building to ensure System of Care sustainability.

5. Developmental Disabilities: This subcommittee, added in 2011, includes members from all systems and focuses on integrating partnerships and guaranteeing children with developmental disabilities receive proper services and supports.

Connections Partnerships

Systems Partners

- Bureau of Substance Abuse
- Detroit-Wayne County Community Mental Health Agency
- Michigan Department of Human Services - Wayne County
- Public School Districts: Detroit, Highland Park School, Inkster, River Rouge, Woodhaven/Brownstown
- The Southeast Michigan Community Alliance
- Third Judicial Circuit
- Wayne County Department of Children & Family Services
- Wayne Regional Educational Service Agenca (RESA)

Partner Agencies

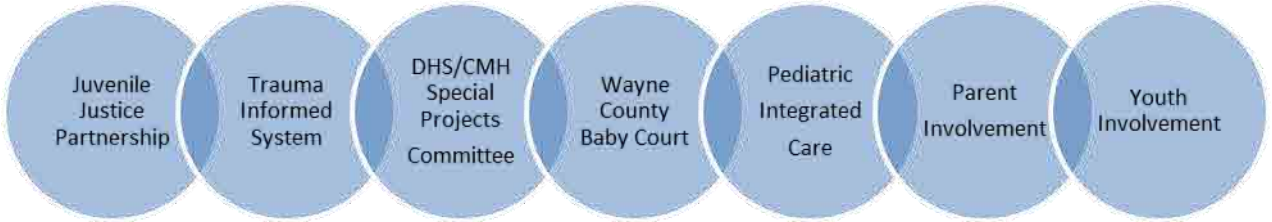
- ACCESS
- Arab American and Chaldean Council
- Black Family Development, Inc.
- Carelink Services
- Community Care Services
- Community Living Services
- Consumer Link Network
- Detroit East Community Mental Health Center
- Development Centers, Inc.
- Eastern Michigan University
- Family Alliance for Change
- Gateway Community Health
- Hegira Programs Inc.
- Learning Center of Excellence
- Lincoln Behavioral Services
- Northeast Guidance Center
- Ruth Ellis Center
- Southwest Counseling Solutions
- Starfish Family Services
- Starr Vista
- Synergy Partners LLC
- The Children's Center
- The Guidance Center
- Youth United

University Partners

- Eastern Michigan University
- University of Michigan
- Wayne State University
- Western Michigan University

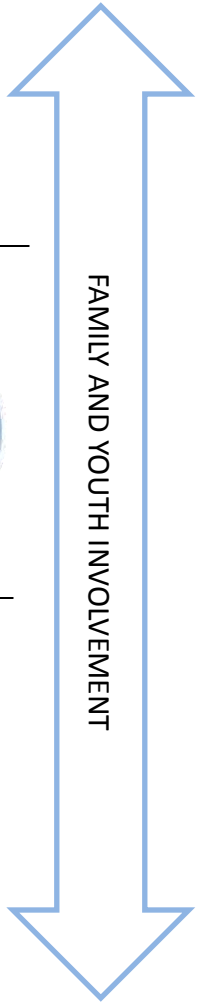
Governance

Community Collaboration



Practice Models

Full Implementation	Training Projects	Demonstration Projects
• Wraparound • Infant Mental Health • Home Based Services • DHS/SED Waiver • Kids Talk CAC	• Multi Family Groups • Parent Management Training: Oregon Model • Trauma Focused Cognitive Behavioral therapy	• Cornerstone (TAYP) • Parent Support Partners • LGBTQ Youth Services



Family Driven - Youth Guided - Community Based - Cultural and Linguistic Competence

Connections Logic Model

Activities	Objectives	Goals
Goal 1 Activities • Pursue grant opportunities to increase funding for system collaboration and access. • Facilitate community education sessions to discuss consumer barriers to CMH services. • Create steering committees to bring systems together to address service delivery and access. • Work collaboratively with other child serving systems. • CMH materials (e.g. pamphlets, brochures) are created and distributed in community. • System partners attend cross-system training. Goal 2 Activities • Facilitate strategic planning sessions to determine program and/or evaluation readiness and required trainings. • Trainings are made available and promoted to providers. • Program self-assessments and evaluations are performed by providers. • Providers review best practice models to support their programs. • Pursue grant opportunities to improve CMH services. • EBP consultants work with providers to offer training and certifications. Goal 3 Activities • Research grant opportunities to increase funding that will allow expansion of youth and parent involvement (e.g. trainings). • Place youth and parents on SOC and D-WCCMHA committees. • Convene meetings with local businesses and stakeholders to address youth under-employment. • Identify trainings for youth (e.g. leadership) and parents. • Evaluate current efforts at increasing youth and parent voice. • Identify barriers that youth encounter when seeking employment and being a visible entity in CMH. • Identify barriers that parents encounter to being a visible entity in CMH. Goal 4 Activities • Partner with the VCE on Workforce Development Activities. • Identify key SME to provide consultants and training. • Create and maintain credentialing and training process for CMHP and BP.	Goal 1 Objectives • Funding is identified and secured for expansion of CMH services. • Increase community awareness of available CMH services. • Increase cross system referrals. • Increase service coordination between WC-CFS to ensure juveniles in JJ system have access to CMH. • Increase service coordination between other child serving systems. Goal 2 Objectives • Increase evaluations of children's services. • Cultural competency issues are addressed at systemic and provider levels. • Providers meet fidelity to EBP models. • Funding is identified and secured to improve quality of CMH services (training, staff, resources). • Providers receive necessary training and technical assistance to sustain programs. • Training requirements are met for individual programs. Goal 3 Objectives • Training and employment opportunities for youth are increased. • Funding is identified and secured to support expansion of youth and parent involvement. • Youth and parents are utilized in different aspects of the CMH system. Goal 4 Objectives • Increase certification of EBP/BP staff. • Increase CMHP credentialing. • Increase workforce skill level. • Workforce will adhere to the standards of the Child Mental Health Professional. • Clinicians providing specialty services maintain appropriate certification, training, and coaching. • VCE supports the ongoing staff development of children and adolescent mental health providers.	Goal 1 Increased access to services for children and youth in the D-WCCMHA. Goal 2 Improved quality of services for children and youth seeking CMH services in Wayne County. Goal 3 Increased youth and parent involvement and voice in the D-WCCMHA. Goal 4 Services will be delivered by a quality, well-trained work force.

Assumptions

1. The size, diversity, and complexity of Wayne County impacts consumer access to comprehensive and quality care.
2. There is a lack of youth and parent involvement and voice in CMH.
3. The "silo effect" that exists between child serving systems inhibits system collaboration and communication.
4. Due to Michigan's economic climate cuts in the General Fund may lead to a Medicaid funded system.
5. There is a push towards integrated healthcare due to Health Care Reform legislation which will impact Medicaid health plans.

Chapter 2: Special Projects

Purpose of Special Projects

Special Projects are developed as a way for Connections to identify and address the specific concerns of cross-system children and youth, in order to move toward greater service integration. While working in partnership with the Wayne County Regional Educational Service Agency and fourteen schools throughout Wayne County, Connections was able to identify systemic barriers for children and youth with serious emotional disturbance (SED) involved with two or more Wayne County Children's Systems. The High-End Project evolved out of the information learned from being in the schools, which gathered data on SED youth that cross multiple systems and cost the most to serve across systems. A year later, Connections is embarking on a new special project addressing the High-End Characteristics (HEC) youth in an attempt to reduce the need for youth using more restrictive and costly levels of care and to identify best practices for this population. The care coordination project (CCP) is the latest special project that has evolved from previous projects targeting SED high users of resources across all children's systems. The CCP will be working in partnership with Wraparound programs to reduce the likelihood of prolong usage of the most restrictive environments for children and youth with SED.

School-Based Special Project

Background

As the System of Care was being developed in Wayne County, members of the collaborative team discovered that access to services was a barrier faced by families with social and emotional difficulties. Since presumably all children attend school, making it an ideal place to identify children from other children's services, the School-Based Special Project was developed. The focus of the program was to identify and understand the problems faced by families when trying to access services. The information obtained in the project would then be used to inform system change and increase service access for families.

Access Coordinators were hired during 2008 to work within school districts, accepting referrals of children who were eligible and/or needed services or were having trouble accessing the services they needed. The Access Coordinator worked with the individual family and the school system to address the barrier being faced, help them to navigate the various systems, and ensure they were connected to appropriate services.

The referral process varied between schools to meet the needs and work within the boundaries of the individual districts. At some schools, coordinators worked closely with the principals or the school counselors, whereas others accepted referrals from teachers who noticed children disrupting their classrooms. Coordinators were generally housed in individual schools, but reached out to all the schools in the district, receiving referrals from elementary, middle, and high schools. One coordinator

developed a relationship with the truancy officer, a common element in each of the schools, who helped to develop communication and lines for referrals between all the schools in the district.

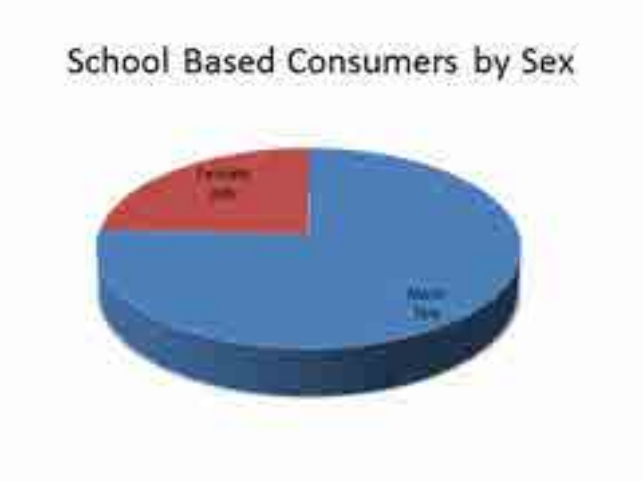
Coordinators also performed additional activities in the schools. They gave presentations about the System of Care services at staff meetings, PTA meetings, and talked to the teachers individually in depth. To make themselves visible, they spent time in the lunchroom or hallways, developing relationships and getting involved in the school. This high visibility helped to gain trust among school officials that were skeptical about the presence of Access Coordinators in the schools.

Characteristics of Program Participants

Throughout the school-based efforts, Connections served 212 children and youth. Ages of clients ranged from 3 years to 18 years, and over half of those served were in the 11-14 year-old age group. The youngest children were often the siblings of school-aged participants, or were referred to the program through other sources.

School-Based Consumers Served by Age		
Age category	**Frequency**	**Percent**
5 and under	6	2.9
6 – 10	48	22.9
11 – 14	110	52.4
15+	46	21.9
Total	210	100.0
No response: (2)		

Over 3 out of 4 children or youth that received the school-based program services were male. 24.2% (51) were female, and 76.8% (161) were male.



The majority of participants self-identified as belonging to either the Caucasian/White or African American/Black ethnic categories.

School-Based Consumers Served by Race/Ethnicity		
Race/Ethnicity	**Frequency**	**Percent**
Caucasian/White	62	29.2
African American/Black	109	51.4
Hispanic	14	6.6
Native American/Alaskan Native	2	0.9
Asian American/Pacific Islander	0	0
Multi-Racial	22	10.4
Not reported	3	1.4
Total	212	100.0

Data was collected on the child or youth's mental health status at the time of the referral. Although all the participants fit the criteria for Serious Emotional Disturbance (SED), a little over half of the participants already had been diagnosed with a specific mental health condition. Information regarding specific diagnoses was not collected because students were not necessarily connected to the mental health system. Slightly fewer than half also were taking medication to treat their conditions. Families were also asked if their child had an Individual Education Plan (IEP) at the school they were attending.

School-Based Consumers Mental Health and Education Status		
Status	**Frequency**	**Percent**
Youth has a mental health diagnosis (n=190)	109	57.4
Youth being treated Rx medication (n=182)	89	48.9
Youth has IEP at school (n=185)	75	40.5

Participation in the school based program was high, and over 90% of families who received a referral continued to be connected to appropriate community services or resources. In some cases, a referral was made to Connections but no system barriers could be identified. Unfortunately, a Connections staff member left the project during the program period, leaving at least three consumers with a gap in services.

School-Based Connections Program Participation		
Type	**Frequency**	**Percent**
Case was opened	192	90.6
Parent declined/did not follow through with services	11	5.2
Referral was made, but no barriers were identified	5	2.4
Case not opened	1	.5
Other	3	1.4
Total	212	100

Barriers Identified

Connections staff recorded details about each barrier encountered by the involved families. General themes were developed, and barriers were found to be faced by both the families and the systems.

Barriers for Families:

All barriers faced by families related to access to care, which were subdivided into three subcategories: Environmental Factors, Knowledge, and Customer Service. Environmental barriers faced by families were contextual problems related to living situation, family circumstances, and logistical complications. For example, a family might not be able to attend an appointment because they do not own a car and public transportation is not affordable or reasonably located near their home. Knowledge was identified as another significant barrier for families, including knowledge of available services, eligibility requirements, and methods of navigating through services to guarantee needs are met. Finally, system-based customer service issues also inhibited access to services. Families met procedural inconsistencies and a lack of communication to families from provider agencies, such as phone calls not being returned or case managers missing appointments without prior notice being given to the families.

Barriers for Systems (Workers):

A number of system-related barriers were identified and included: gaps in the service array, lack of communication, and access. Workers noted gaps in services and unmet needs faced by families needed to obtain optimal care. For example, a child with special needs and behavioral issues might have a harder time being placed in an appropriately trained foster family. "Silo Thinking" appears to be a prevalent problem, where a worker within a system does not understand the goals, policies, and procedures of another system. As a result, the systems are not coordinating or communicating with each other, causing difficulties for families needing services.

Workers also experience problems coordinating and communicating within their own system, due to a lack of knowledge about available resources, bureaucratic challenges, and high case loads. Access is a challenge faced by workers as well as families. Knowledge about available services and methods to connect families to services can be lacking. Due to silo thinking, knowledge gaps are especially prevalent

concerning available services across systems. Customer service is also an issue, with workers not returning phone calls or missing appointments with families.

Finally, individual system policies may create barriers for youth and families. Many of these policies have been developed to meet the needs and goals of the individual systems yet inhibit care when cross-system services are required. An example that was identified involved funding source confusion for a youth in foster care, which resulted in a lack of continuity of mental health treatment.

Identified Barriers			
	Category	**Subcategory**	**Example**
Family Barriers	Access	Environmental Factors	Family cannot attend scheduled appointment because they do not own a car and public transportation is not available near their residence.
		Knowledge	Family is not aware of available mental health services that they may be eligible for.
		Customer Service	Phone calls are not being returned from service providers.
System Barriers	Gap in Service Array		Family with children involved in Juvenile Justice request respite care, yet no respite is offered through JJ.
	Lack of Communication	Between systems	Relationships do not exist between CMH and police departments.
		Within systems	Delays in completion and implementation of IEPs.
	Access	Knowledge	A school employee identifies a child with behavior issues, but does not know how to connect the child to services.
		Customer Service	Case manager did not show and did not contact family to let them know that appointment would be canceled.
	System-Specific Policies		Lack of continuity of mental health treatment for a youth due to confusion about funding sources while youth is in foster care.

Project Challenges and Successes

Challenges

Developing Trust and Relaying Purpose of SOC

Establishing relationships within the schools proved to be a major challenge. With the exception of one district, where a connection to services was already in place, Access Coordinators had to develop relationships within the districts. A change in leadership with the largest school district in Wayne County resulted in the need to develop individual relationships with school principals. In one case, two prior Access Coordinators failed to connect with a principal that was skeptical of the project. By developing a relationship with other school officials, especially the principal's secretary, however, the Access Coordinator was able to establish a presence within that particular school.

At many schools, staff was suspicious of the SOC's involvement. Due to the political climate in school districts regarding outsourcing, some expressed concerns that the school would start to contract out services or replace them. Other staff members within the schools were unclear about the role of Access Coordinators and wanted them to help do their jobs. Coordinators were often asked to perform activities that were not within the scope of School-Based Special Project. For example, one school provided a list of truant students and asked the Coordinator to track them down on a daily basis. Others wanted the Access Coordinators to provide long-term counseling to students. In many cases, Access Coordinators built trust by taking on non-traditional roles and by assuring school administrators that concerns were being addressed.

Environmental Issues

Space was identified as a barrier at some schools. Access Coordinators were placed in storage closest or out in portable adjacent buildings where it was difficult to be visible and maintain connections with staff housed in the main school. Others were housed in the administrative section of the schools, which caused them to feel disconnected, and one school closed down during the school year.

Staff Turnover

High staff turnover was present during the first months of the school-based efforts. Some coordinators were not comfortable with the flexibility required during a start-up program and the subsequent refining of the job description. Responsibilities included working in the field, in high-risk neighborhoods and developing relationships with people who were not always receptive, which proved difficult for some new hires. Also, during the first few months the staff members were very detached from each other, housed alone in different sites across the county. Some coordinators left for other opportunities.

Successes

Identifying Barriers to CMH Services

Barriers to access were identified at both the family and system level. Families struggled to reach services because of environmental issues, a lack of knowledge about available services, and poor customer service from service providers. Systems were faced with some of the same barriers, such as

service employees who did not know how to connect a child to services. A lack of communication between systems and within systems, as well as system specific policies, was also identified as barriers to access.

Improved Relationship with Schools

Schools are an important system partner in a system of care. This Special Project provided an opportunity to engage with schools, develop partnerships, and educate school administration and staff about services available in the community.

Universal Release and Memorandum of Understanding (MOU)

Two important documents came out of the School-Based Special Project. A Universal Release was approved which allowed a caregiver to permit the release of all records from Detroit-Wayne County Community Mental Health Agency, Wayne County Child and Family Services, the Department of Human Services, and the educational system to Connections.

Satisfaction and Outcome Interviews

Nearly a year after the school-based project was completed, Connections staff conducted interviews with participating caregivers. 156 of the 212 families were contacted, and approximately 24% (37) of caregivers completed the short telephone interview. The response rate is noteworthy, especially since nearly 40% (62) of homes that were contacted had a disconnected or different telephone number than had been identified when referred to the program.

Respondents were asked six questions regarding their experience in the school-based Special Project and subsequent outcomes. If new system barriers had been experienced, the Connections staff member attempted to provide the assistance needed to address and overcome the problems.

Respondent Characteristics

37 caregivers completed the follow-up interview. All respondents had utilized the Connections services. To keep the interview brief, detailed information regarding the child's family status was not collected, but demographic data was available from the time of the child's referral to Connections. Nearly half of respondents had children age 11-14 at the time of referral, and over 80% of the children were male. 40% of children had an IEP at their school, the same as the general population of children served in this project.

Child's Age at Referral to Connections		
Age category	**Frequency**	**Percent**
5 and under	0	0
6 – 10	10	27.0
11 – 14	17	45.9
15+	10	27.0
Total	37	100.0

Child's Sex		
Sex	**Frequency**	**Percent**
Male	30	81.1
Female	7	18.9
Total	37	100.0

Child's Race/Ethnicity		
Racial/Ethnic Category	**Frequency**	**Percent**
Caucasian/White	5	13.5
African American/Black	26	70.3
Hispanic	1	2.7
Native American/Alaskan Native	0	0
Asian American/Pacific Islander	0	0
Multi-Racial	0	0
Not reported	0	0
Total	37	100.0

Approximately 3 out of 4 survey respondents had children who were involved in mental health services at the time of referral. The rate of involvement in services among the sample is higher than the general population served in this project, where only 57% had a mental health diagnosis and 48% were taking medication at the time of referral.

Mental Health Status at Time of Referral		
Status	**Frequency**	**Percent**
Youth has a mental health diagnosis (n=36)	27	75.0
Youth being treated with Prescription medication (n=35)	25	71.4

Responses

Overall, responses to the interview were positive. Caregivers enjoyed their experience with the Special Project, and felt that the service helped their children improve in school and stay connected to CMH services. A number of respondents reported still experiencing barriers, and nearly all would use the service again if it was available. This suggests that the Connections school-based project addressed a need for families who were experiencing system barriers.

1. Was the School-Based Connections Program successful for your family?

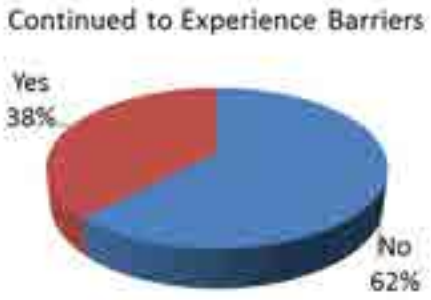
Success of School-Based Program	
Response	**Frequency (n=35)**
No	3 (8.6%)
Yes	32 (86.5%)

Comments:

- "Services went well, helped with DHS and worked out an issue I was having."
- "Very thankful."
- "He walked me through what I needed to do to get services."
- "SOC was successful for my family."
- "I learned a lot about special education laws, etc."
- "Helped get my Medicaid problem taken care of."
- "Didn't use the services."
- "I wasn't invited to a meeting I should have been at; a coordinator lied to me."

2. Are you still experiencing barriers?

Continued Barriers	
Response	**Frequency (n=37)**
No	23 (62.2%)
Yes	14 (37.8%)



Comments:

Among the respondents that reported still experiencing barriers, the majority reported continued problems with their children's schools.

- "Still experiencing problems with DHS and school."
- "My son's teacher is saying inappropriate things to him."
- "The school doesn't follow my son's IEP."
- "My son hasn't passed a class in two years but the school keeps moving him through grades."

Several caregivers identified their child, not the system, as the problem.

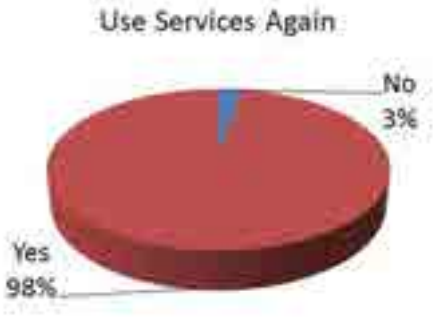
- "My son has the same behavior."
- "My daughter is still having problems in school, but she is the real barrier."
- "My daughter doesn't want to go to high school. The school is cooperating, but my daughter is not."

Others described some continuing problems with the social service systems.

- "I'm trying to get my son back in CMH, but I keep getting denied."
- "I'm having problems getting in touch with my CMH counselor."
- "I had to take the DHS to court to get my Medicaid restored."
- "I need to reconnect with services. I missed a number of appointments and got terminated."

3. If this service was available, would you use it again?

Would Utilize Services Again	
Response	**Frequency (n=36)**
No	1 (2.8%)
Yes	35 (97.2%)

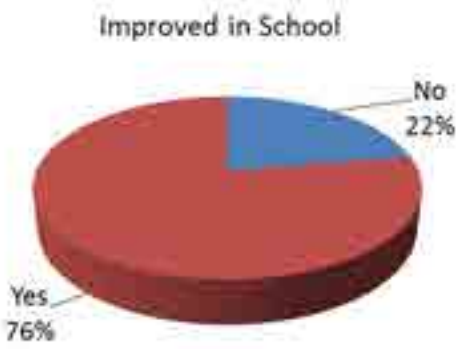


Comments:

- "It was awesome."
- "And I would recommend them to others."
- "I want to be contacted if it becomes available again."
- "Not happy with counseling received."
- "Yes, with another worker."

4. Has your child improved in school? If so, how?

Improvement in Schools	
Response	**Frequency (n=36)**
No/ Stayed the same	28 (75.7%)
Yes	8 (21.8%)



Comments:

Several families noted improvement following the SOC services, yet their children's behavior relapsed over time.

- "It was better for a period of time, but the bad behavior is back."
- "Improved slightly, then fell again."
- "Doing better while he was receiving counseling, but not anymore."

Others experienced more long-term improvement.

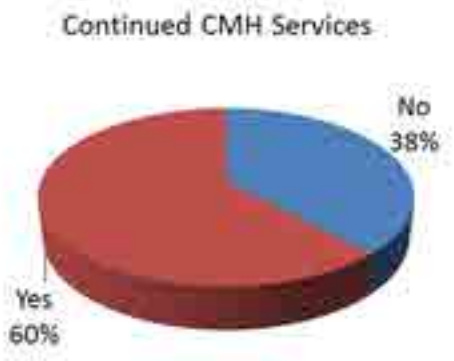
- "My child was able to get in an autistic classroom, and school now provides transportation."
- "He likes school now, and likes his class!"
- "Doing better in school, he's getting good grades, and I understand his IEP."
- "Grades have gone up, he's reading well and wants to show off his report card."

Some respondents did not see any change in their child's success at school.

- "The behavior is better, but grades are not because the school isn't following his IEP."
- "Not much better, pretty much the same as last year."
- "She won't leave the house to go to high school."
- "He just doesn't try, school doesn't care about him."

5. Is your family still connected to CMH? If so, what services are being utilized?

Continued CMH Services	
Response	**Frequency (n=35)**
No	13 (37.1%)
Yes	21 (60.0%)



Services utilized varied among families who were still connected to D-WCCMHA, yet the majority was receiving individual therapy. Consumers also were also utilizing psychiatric services, family therapy, and individual therapy in-home, at school, or in a residential facility. Some consumers utilized multiple services; for example, many children were involved in individual therapy as well as receiving psychiatric services.

Among respondents who had a mental health diagnosis (n=27) at the time of referral, 70.4% (n=19) were continuing to receive services a year after involvement in the program. Three other caregivers noted an understanding that their children still needed services, but were unable to receive them due to

aging out of the system and Medicaid discrepancies. Additionally, two caregivers reported that their children were now receiving CMH services, when they did not have a diagnosis at the time of referral.

6. Are there any additional comments you would like to add?

At the completion of the interview, caregivers were asked if they had any additional comments or suggestions regarding their experience with Connections.

Most respondents had very positive comments:

- "SOC was very helpful for me at a time when I was frustrated."
- "He was helpful, told me how the system worked."
- "I would recommend it to others because it does help. My grandson just didn't want the services offered."
- "I liked it because if I ever needed anything they were always there for me. I'm still connected to [Family Alliance for Change]."

One caregiver offered a suggestion for improvement:

- "If you go back into schools, talk with the School Social Worker and find out who the foster care kids are, they and their foster care parents are in need of a lot of help that schools sometimes cannot provide. SSW can introduce family to services as well. Foster care parents are told there are no services and in fact there are."

Results by Group

In an effort to determine if the School-based Special Project worked better for some consumers than others, responses were also analyzed by age group, sex, presence of a mental health diagnosis, and presence of an IEP. No notable differences were found between the groups. Self-reported success of the program was slightly higher for younger children than older children.

High-End User Project

Background

The High-End User Project began in the fall of 2010 to identify children who are the most expensive within all child-serving systems and facilitate their transition to less restrictive environments through cross-system collaboration. Three county systems, the Department of Human Services, Detroit-Wayne County Community Mental Health Agency, and the Wayne County Department of Children and Family Services identified youth that utilize the most restrictive environments and incur the highest costs, and made recommendations to Connections System of Care.

Goals

1. Identify unmet needs of high-end users.
2. Understand the contributing factors that lead to high-end users.
3. Move high-end users into less restrictive settings.

Methods

Referrals

Although each partnering system has its own criteria for determining a high end user, the following were used as a general guide for all systems.

Primary Criteria:

1. Serious Emotional Disturbance (SED) diagnosis
2. High cost of care
3. Age 5-17, with the exception of youth involved in the Juvenile Justice System. Depending on the offense, youth may not age out of the JJ system until age 19-21.
4. Numerous/long-term (ongoing) hospitalizations or residential stays exceeding six consecutive months, or involvement with multiple restrictive environments
5. Resident of Wayne County
6. Identified by collaborating systems in the SOC partnership (DHS, CAFS-JJ, CMH, Education)

Secondary Criteria:

1. Community Mental Health youth
2. Youth is at risk for out-of-home placement for a second time
3. Youth is at risk for becoming a High End User
    a. Receiving services consecutively for one year or more
    b. Scheduled weekly therapeutic appointments with CMH/JJ systems
    c. Limited or no milestones achieved (No CAFAS reduction, behavioral concerns escalating, etc.)

Referrals and Costs by System			
System	**# of Referrals**	**Eligible Cases**	**Cost**
CAFS- JJ	29	27	$6,335,946 spent over 4 years
DHS	60	20	$1,971,584 spent over 1 year
CMH MCPN: CareLink MCPN: Gateway Partnering Agencies	 20 10 11	 20 10 11	$1,802,322 spent over 1 year $1,152,931 $649,391 (cost not given/calculated)
Total	130	88	$10,157,121 spent over 4 years

Case Review

Once each system identified the children and youth determined to be most in need of cross-system support, Connections Access Coordinators began the process of dissecting their complicated case histories. Case review included a thorough review of client documentation, including patient charts and electronic medical records from all systems the client has ever encountered, and interviews with parents, therapists, and other individuals involved with client care. A 24 item comprehensive High End Case Analysis Assessment was then completed, which cataloged presenting problems, family history, diagnoses, and a timeline of treatment, services, and hospitalizations. Demographic information was also collected.

Analysis

Common elements were identified as precursors to the children and youth's current conditions as were common cross-system needs for services and structures necessary to move them to less restrictive and more stable placement options. Other common themes and system issues were also identified, such as access, trauma, service gap, etc.

Example: Case Study

The following is an excerpt of a true story from Connections High-End User Special Project. The name has been changed to protect the family's privacy.

John is an 18-year old male who entered the mental health system at age 13, needing outpatient services for suicidal/homicidal ideations, abusive behavior, and issues noted as Impulse Control and Indecent Exposure. At age 14, he was charged with a Criminal Sexual Conduct (CSC) II offense and Indecent Exposure; a year later was adjudicated and placed in Wayne County Juvenile Detention Facility. In 2006, at the age of 14 his CAFAS was 170. Furthermore, he was diagnosed with Conduct Disorder, Schizophrenia, Attention Deficit Hyperactivity Disorder (ADHD), Pyromania, and sexual inappropriateness. By 2009, he had received additional diagnosis of Oppositional Defiance Disorder (ODD), Depressive Disorder, Paraphilia, Aspersers, and Autistic Spectrum Disorder; in total, he has had

ten (10) diagnoses and/or offenses. His charts disclosed that his older half-brother sexually assaulted John from age 7-13.

John has been placed out of home since he was 14 and upon completion of this analysis at age 17 resided in a residential setting. At the time of John's entry into the CMH/JJ systems, John's mother worked as an Intake Worker for a correctional institution and fully participated in family therapy. She informed therapist she was diagnosed with depression and was divorced from John's biological father. John's father lived out-of-state, but participated in biweekly family sessions via phone. His stated that he does not agree with the allegation that his other son sexually abused John; however, the case is in the adult corrections system. John reported he sexually assaulted nine children (boys and girls) by age fourteen. John received special education services due to being identified as emotionally impaired (EI) from the first grade. The youth maintained a 2.0 grade point average in the residential facility and an IEP was completed in 2005 at the age of 13.

This case was submitted to Connections' High-End Special Project for review in 2010, but the process was not yet in place to fully assist in moving John back into the community with the services and supports needed to sustain him. From 2006-2010 Juvenile Justice has spent an estimate of $258,199 and CMH $151,900 totaling $410,099 on John's residential care. Brief CMH services in the community for 5-days in 2005 and 7-days in 2009 were not calculated in the overall estimate of service cost.

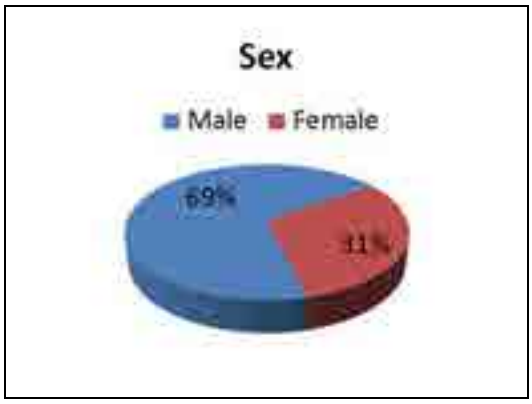
Findings

High End User Characteristics: ALL

As of October 1, 2011, 60 case analyses have been completed.

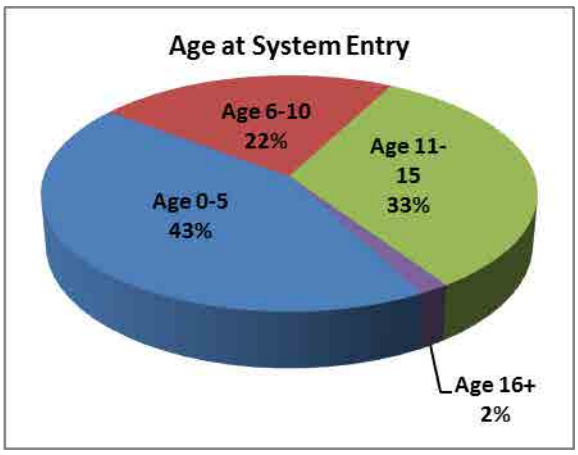
1. Sex

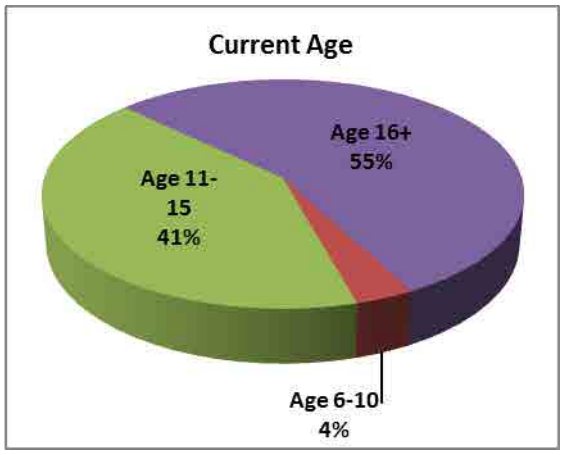
- 69.5% male, 30.5% female



2. Age

- Average age (current): 15.64 years
  Range: 8 – 21 years
- Average age (entry into any children's service system): 7.36 years
  Range: 0 – 17 years





3. Race/Ethnicity

Ethnicity		
	Frequency	Percent
African American/Black	37	61.7
Caucasian/White	8	13.3
Hispanic/Latino	1	1.7
Biracial/Multiracial	2	3.3
Not noted/Missing	12	20.0

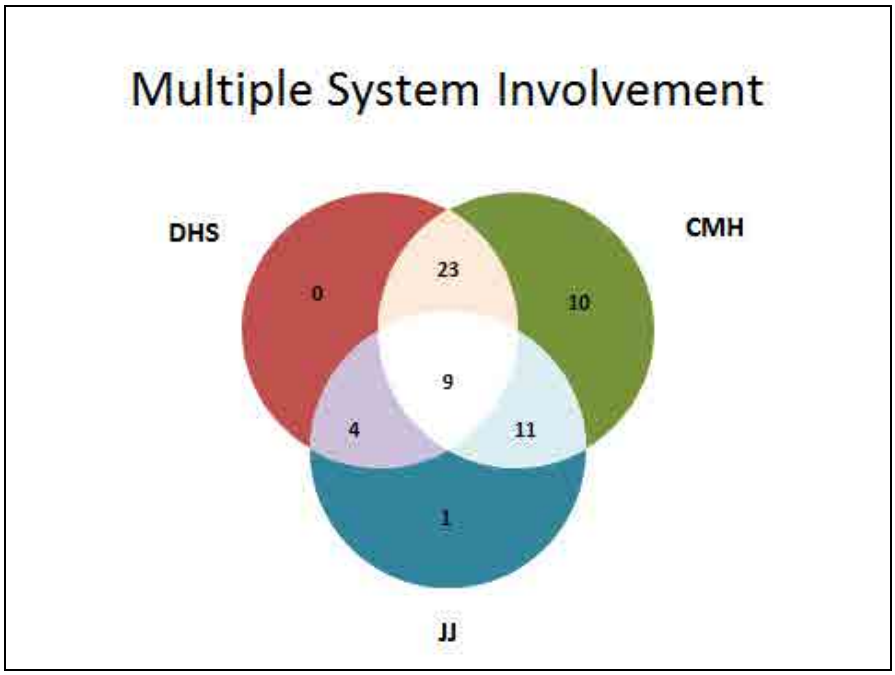
4. Residential Stays

- Average Length of System Involvement: 8.4 years
  Range: 1 – 17
- Average Number of Out of Home Placements: 7.82
  Range: 1 – 30
- Average Number of Days Spent in Out of Home Placements: 1,036 days (2.83 years)
  Range: 0 – 3,962 (10.85 years)

5. System Involvement

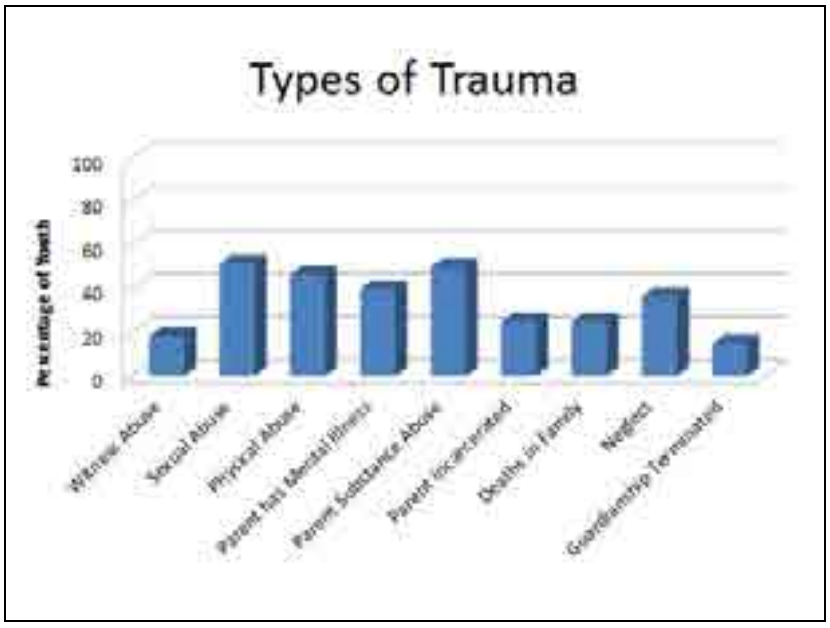
- 55% had Special Education Designation while in school (EI)
- 81% have been involved in multiple systems during their life
- 16.7% had been involved in all three systems: DHS, CMH, and JJ

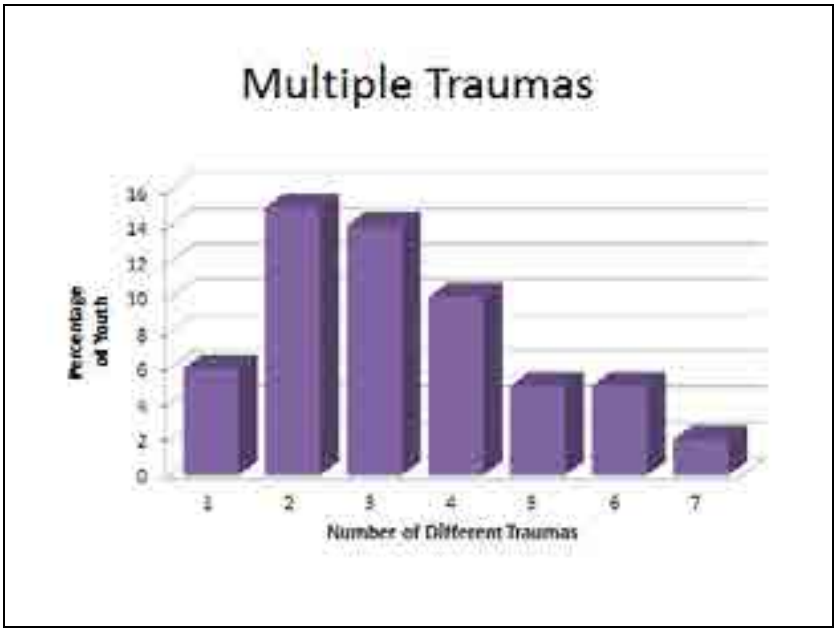
The diagram below displays the distribution of multi-system involvement among high-end users in this project. 81% of these youth had been involved in more than one system. Youth most commonly had been involved in CMH and DHS, though nine consumers had touched all three systems at one time in their life. Cross-system involvement is common for many children and youth, which further supports the need for system collaboration.



6. Trauma

- 95% had a history of trauma
- Of those with a history of trauma, 90% had experienced multiple traumas





High End User Characteristics: Differences by Referring System

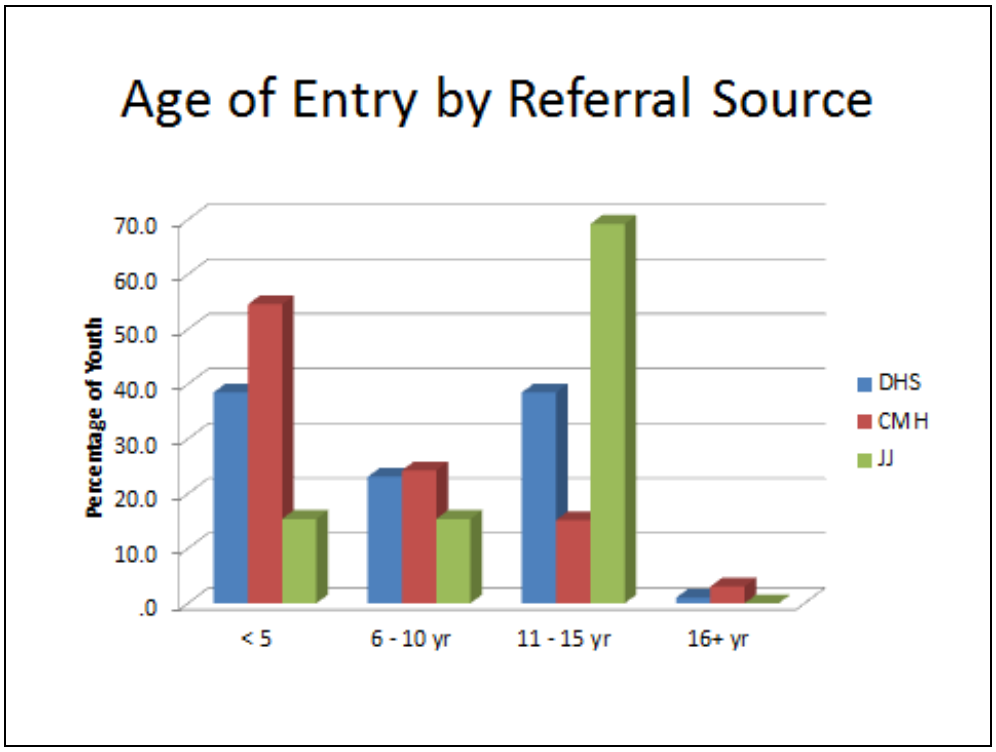
Referrals

System	# of Referrals	Eligible Cases	Completed Analysis
CAFS- JJ	29	27	14
DHS	60	20	13
CMH	30	41	33
Total	*119*	*88*	*60*

1. Sex

2a. Age of Entry

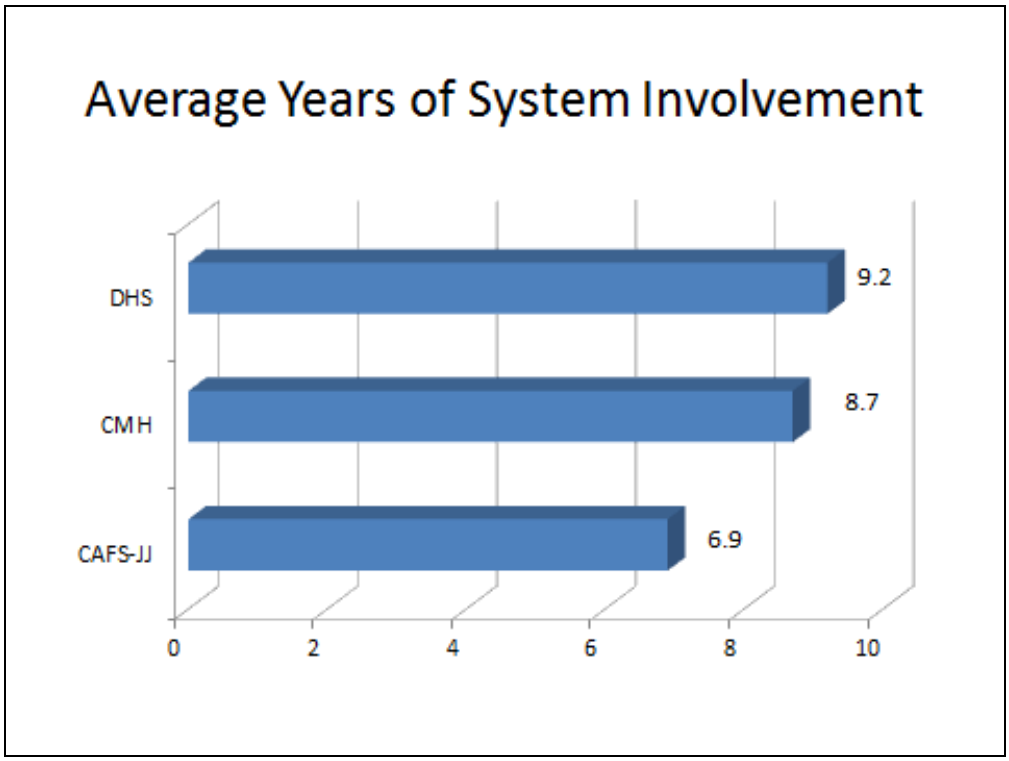
	Entry into Any System			Entry into Referral System		
System	**Average**	**Minimum**	**Maximum**	**Average**	**Minimum**	**Maximum**
DHS (n=14)	7	0	12	7	1	12
CMH (n=32)	6	0	17	8	3	17
CAFS- JJ (n=13)	11	4	15	13	11	14
All Systems (n=60)	7	0	17	8.5	1	17



2b. Current Age

System	Average Age	Minimum Age	Maximum Age
DHS (n=14)	16	12	18
CMH (n=32)	15	8	18
CAFS- JJ (n=13)	13	14	21
All Systems (n=60)	15	8	21

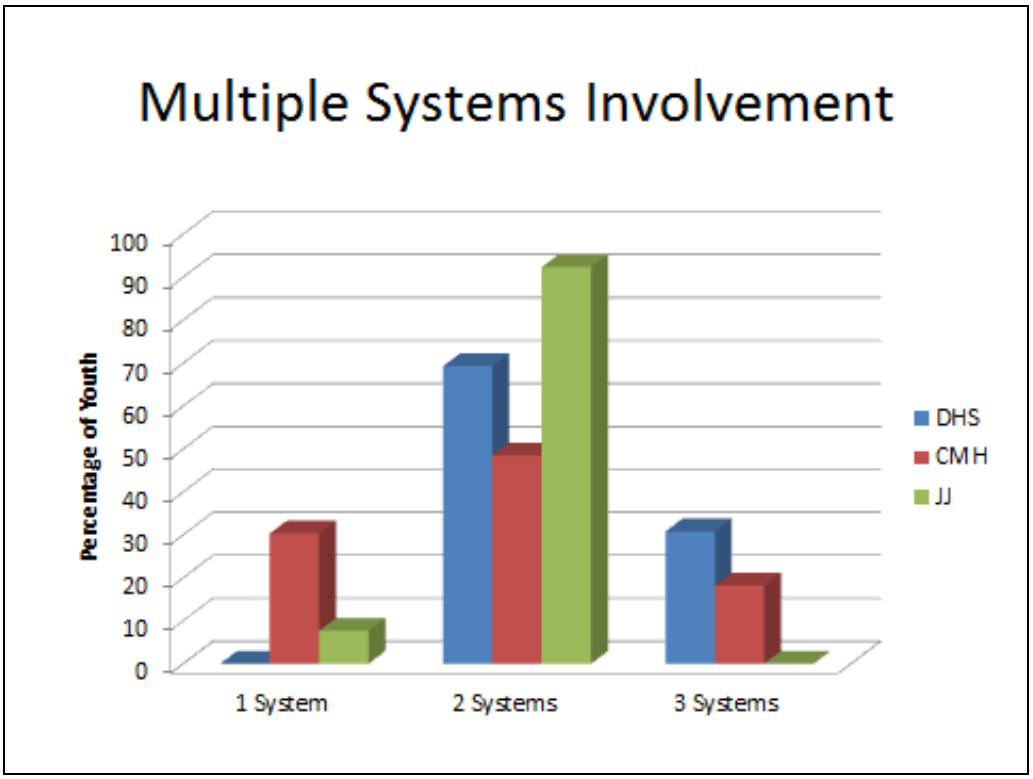
2c. Years of System Involvement



3. Out Of Home Placements

	Number of Stays			Days of Stay		
System	**Average**	**Minimum**	**Maximum**	**Average**	**Minimum**	**Maximum**
DHS (n=14)	7.8	4	14	1203	86	3962
CMH (n=32)	7	1	21	656	0	1884
CAFS- JJ (n=13)	10.8	1	30	1565	256	2555
All Systems (n=60)	7.8	1	30	6	86	3962

4. Cross-System Involvement



5. Special Education Needs

n=60

**45% of high-end users were receiving special education services. Among these, 88% had an Emotional Impairment (EI) designation, 7% had a Learning Disability (LD) designation, and 4% had a Developmental Disability designation. Among those with an EI designation, 6.5% also had a Developmental Disability designation, 3.2% had a speech designation, and 3.2% had a Learning Disability designation.*

6. Trauma

An overwhelming majority of all high-end youth, regardless of referral system, had experienced early trauma.

High-End User Themes and System Issues

Trauma

95% of High End Users experienced a history of traumatic events, including sexual abuse, physical abuse, neglect, history of parental mental illness, incarceration of parent, deaths of family members, and the termination of parental guardianship. Additionally, 90% have experienced at least 2 different types of trauma (i.e. sexual and physical abuse, neglect and physical abuse). These traumatic events were addressed in less than 15% of cases, often without success.

Adolescent Perpetrators

Several high-end users have become perpetrators themselves. 100% of adolescent perpetrators in this sample of high-end users had experienced a history of sexual abuse. Systems must address the need for placement of youth that have not been convicted, yet can no longer reside in the family home. Early treatment for the victim of the high-end youth (usually a family member) is also essential to prevent the development of high-end behavior in the future.

"Wrong" System Entry

Youth are entering the "wrong system" initially and having trouble getting streamlined into the correct system. For example, a youth might enter the system through Juvenile Justice due to behavioral issues, but has underlying mental health problems. These mental health problems subsequently cause long out of home placements in a behavior-focused system.

Incorrigibility

In many cases, high-end user behaviors have gotten so severe that the parent can no longer handle the youth living at home. Parents then petition for incorrigibility to maintain safety in the home. However, parents do not always understand the consequences of filing an incorrigibility petition.

Residential Payment

Managing youth involved in multiple payer systems is always a challenge, and disputes continue over where funding for residential stays should come from when a youth is involved in multiple systems.

Educational Barriers

Youth with extensive residential and/or hospital stays are faced with multiple barriers when returning to their community schools. Lack of coordination between systems, educational credits lost or not honored

by public school districts upon readmission, placement in appropriate grade level, existing IEPs not being implemented and/or new ones not being established are examples of educational barriers.

Discussion and Recommendations

Special Projects allow Connections to identify specific problems or populations that require additional attention and investigate them further, as well as make systemic changes to transform the system if possible. The School-Based Special Project identified a number of barriers to access and piloted a way for Connections staff to help families navigate the various systems.

Key Findings from School-Based Special Project

1. Barriers to access were identified, and exist at both the consumer and system level.
2. Families were satisfied with assistance accessing services.
3. The education system was not familiar with accessing other systems, child-serving programs, and other community resources that could assist in supporting educational success.
4. A lack of understanding of SED and other behavior challenges exists throughout systems in Wayne County.

Recommendations

1. The School-Based Special Project seemed to meet a need for families in Wayne County who had a need for services but were experiencing barriers to access. Nearly 40% of families that completed the follow-up survey noted that they were still experiencing barriers and could benefit from a Connections Access Coordinator helping to navigate them through the system.

The High-End User Project identified children with the most severe emotional and behavioral problems across three partnering systems. Through comprehensive case analysis, Connections was able to gain a better understanding of the youth with the most complex needs. This knowledge will be used to inform future policies and program implementation.

Key Findings from High-End User Project

1. Children and youth with the most complex needs are usually involved in multiple systems.
2. High End children are involved in systems for an average of 7 years.
3. The average High End child has experienced multiple traumas, and has spent an average of 4.5 years in out-of-home placement.
4. Many High End youth are aging out of the child system.
5. Future efforts need to invest in evidence based practices that meet the needs of these unique youth, including further collaboration between systems.

Recommendations

1. Develop a method for system partners to work collaboratively to move High End users out of placements and back to the community.

2. Use the data presented above to prevent future High End Users through early identification and intensive treatment.
3. Investigate the aging out problem. By the time many youth become High End Users, many years have been spent in the systems and the youth are nearing adulthood. A focus on transition programs is necessary to guarantee a continuity of care from youth to adulthood.

Chapter 3: Youth Involvement

Youth and family involvement is central to system of care philosophy. From broad system leadership to direct service providers, youth and family input is encouraged and used to guide decision making, treatment plans, and outcomes. In Wayne County, two groups lead these efforts: Family Alliance for Change (formerly the Association for Children's Mental Health in Wayne County) and Youth United.

In early 2011, Connections hired lead youth advocates for all provider agencies and tasked them with increasing youth voice in the system of care. A focus group took place to learn how youth advocates were filling their role. The results of this discussion are presented below.

Connections Lead Youth Advocates Focus Group Findings

Background

At the end of September 2011, a focus group was held with the Connections Lead Youth Advocates to discuss activities and accomplishments that had taken place during the previous fiscal year. The Children Services Liaison and six Lead Youth Advocates participated in the discussion, which was moderated by the Connections research associate. Since the advocates were not hired until spring of 2011, the majority of events described occurred between April and September.

Findings

Activities

Lead Youth Advocates (LYAs) participate in a variety of activities across the county, including coordinating and facilitating Youth United Meetings, executing youth outreach, and representing youth on committees.

1. Youth United Meetings

In an effort to increase the voice of Youth United across Wayne County, LYAs currently hold or are planning to hold regular youth meetings at their home agencies. Youth are recruited to join these meetings through flyers posted in locations frequented by youth, referrals from clinicians at the provider agencies, and direct in-person outreach.

One LYA described a recent meeting:

> *At my group just recently, we talked about relationships. That's one of the topics that my youth wanted to talk about. First we introduced ourselves, then we did an icebreaker… and then afterwards I asked them if they wanted to talk about relationships between their parents and them or people in their school. But we ended up talking about relationships between parents,*

and I gave them advice about how to deal with difficulties with their parents, like if they don't agree with their parents.

Some LYAs have built upon existing groups at their home agencies, while others are in the process of forming new groups. In addition to being a source for youth empowerment and voice, LYAs act as a mentor to the youth in their groups, and teach leadership and public speaking skills. As Youth United expands, it is hoped that a new level of leadership will be developed from the youth groups.

2. Youth Outreach

LYAs also are responsible for increasing participation in Youth United activities, which they do through various outreach activities. Generally, LYAs will visit a targeted place with a concentration of young people and talk to them about Youth United. Flyers are distributed and youth are encouraged to join the efforts. Schools, parks, and recreation centers are common locations for outreach, but methods vary by location. For example, referrals from clinicians are common at agencies that see a large population of youth.

A LYA shared how they approached a group of young people walking home from school:

We parked and walked up to them and were like "How are you doing? We've got this group." We told them who we are and what we do… and what we're about, and what benefits come with the group… The more voices we have, the more change we can do. Most of them were saying they couldn't come because they had basketball practice or whatever after school, but we got a couple young ladies that were interested. The first group we had turned out pretty good.

3. Committee Membership

LYAs contribute a youth voice on many committees that make decisions about children's policies in Wayne County as well as across the state, including cross-system leadership meetings, development and funding committees, statewide community organizing planning committees, and community teams for youth receiving Wraparound services. Throughout the next year, LYAs hope to be represented on all committees and develop a reciprocal relationship where they can provide a youth perspective as well as access support and resources.

Acting as youth representatives on committees with high-level decision makers can be challenging. For the first several meetings, the LYAs are often trying to understand the purpose of the committee and their role within it. A LYA described feeling overwhelmed at a recent committee meeting:

I went to my first committee, it was a pediatric health committee, and on my first day I was sitting there looking around like I don't even know why I'm here... There were so many people there from Wayne County. I was just observing, taking it all in.

Processes are being put in place to ease the transition onto these committees. In order to guarantee that the LYA feels comfortable and familiar enough with the committee purposes, the Children's

Services Liaison has begun to pair them up with a committee chair or co-chair. The committee leadership will help the LYA get orientated, explain previous projects of the committee, and act as a point person for answering questions, especially regarding explanations of terms or acronyms.

Several positive outcomes have already come from LYA's committee membership. The developing team for Person's Point of View, a Wayne County newsletter, has relied on LYAs for input and technical support. Youth United will have a regular column in that newsletter which will report on activities and accomplishment. Youth presences on the Partnership Initiative Meeting lead to a partnership with the county to implement an anti-stigma toolkit in the upcoming year. Additionally, youth involvement on the Connections Development Committee guaranteed that youth issues were accounted for on the logic models.

Accomplishments

Throughout the discussion, LYAs alluded to a number of accomplishments that were made, both personally and for Youth United as a whole. Several of these accomplishments are detailed below.

- LYAs were hired for each partnering agency.
- A youth advocate was chosen to be the focus of an e-newsletter sent to the home provider agency. The article highlighted how the LYA became involved in Youth United, how Youth United is developing at the agency, and the benefits of having youth voice in decision making.
- Five of the nine LYAs attended training and are certified Wraparound facilitators.
- LYAs provide a youth perspective on Community Team meetings for youth in Wraparound.
- Several LYA gave presentations at elementary schools during Mental Health awareness month about mental health and services. At one school, the group had several children line up in front of the auditorium stage and read different stories about youth with different mental illnesses. The hands-on learning experience was enjoyed by the participants.
- LYAs developed a partnership with county leadership to implement the anti-stigma toolkit in 2012. Youth United had planned to implement the toolkit themselves, but partnering with more powerful stakeholders will help increase the impact of the efforts and hopefully increase the youth movement throughout the county.
- A LYA addressed the Association of Children's Mental Health, describing issues of parental understanding when a youth discloses their sexual orientation. This was one of the first times ACMH had discussed LGBTQ issues, and the parents were enthusiastic to learn from the LYA.

Additionally, LYAs expressed gratitude for being allowed the opportunity to represent youth voice. In addition to getting to lead the youth community toward positive chance, the LYAs have found their work to be valuable and a good learning experience.

LYAs added the following comments:

> *And [committee members] are looking at you like you're only 19, we've finished school and all this, and it kind of makes you feel like you're somebody. So it's a great learning experience.*

I never thought I would be sitting in this chair and doing the things that we do, so I appreciate them giving me a chance to be a LYA.

I've been to stuff that I had only seen on TV, like they do cancer walks on TV and I always wanted to do that but didn't know how to get associated with it. But through this whole program I've been places that I never thought I'd have been. And I'm just having fun, and I'm down to do some more.

[Being a LYA] was a great opportunity to me because I was looking for a job that wasn't something you just went in and did your thing for five hours, that you dreaded. One that you could help others as well.

Barriers

LYAs expressed a number of challenges they faced in their work, as well as difficulties faced when trying recruiting more youth to participate in Youth United. Lack of transportation and lack of youth support were mentioned as major barriers to increasing youth participation, as well as problems with partner agencies.

1. Transportation

Transportation is a great challenge faced by many programs in Wayne County, and Youth United is not an exception. LYAs are housed at different agencies throughout the county and find it difficult to acquire transportation to get together for meetings, travel to outside cities to give presentations, and do youth outreach.

2. Lack of youth buy-in

At times, youth are less than enthusiastic about being asked to be a part of Youth United because they are not interested or are too busy with other activities. One LYA estimated that of a group of ten youth, one might attend a Youth United Meeting. To combat this issue, LYAs stress the importance of finding common interests at first contact, and also spending the first several meetings getting youth engaged in the group.

3. People and Agencies that are not youth-friendly

Some partner agencies and their employees have yet to understand the purpose of the LYA and completely buy into the idea of including youth voice. For example, meetings are often scheduled for early mornings, when youth are in school or cannot access transportation to attend the meeting. LYAs feel that at times they are not given the level of respect afforded to other employees of their agencies, and feel they have to keep explaining their purpose and need for space and resources. Some LYAs face restrictions, such as the use of the company car or limits on the places where LYAs can do outreach. Although each LYA has a supervisor at their home agency, these supervisors often carry a heavy caseload or supervise several programs, preventing them from devoting a lot of attention to the LYA and the other youth advocates they are trying to train.

Future Directions

Overwhelmingly, the LYAs described a desire to see Youth United grow and develop a positive reputation in the community. They envision a future where Youth United has a strong relationship with the local news, so youth voice can get out regarding issues or local policies, and youth are increasingly acting toward change. Additionally, LYAs and Youth United leaders will act as role models and advocates for youth in their communities.

LYAs would also like to see Wayne County develop a drop-in youth center similar to the one visited in Howell, MI. The center housed a number of life skills and substance abuse groups, and also allowed a place for youth to visit and relax with games and musical instruments and free food. An additional center across the street also provided shelter for up to two weeks, given the parents' permission. This shelter provided a structured environment for youth that needed a break from their current living situation, and who would otherwise be staying on the streets.

All agree that the group is headed in the right direction and are excited to see what the future of Youth United will bring.

Summary & Recommendations

2011 was an important year in the development of Youth United. Lead youth advocates were hired at partner agencies and are responsible for organizing youth in the community, providing oversight for all Connections activities, and informing the strategic direction of the system of care.

Recommendations:

1. Work to further instill the values of Connections, especially youth participation and voice, at the organization and system levels. Although Connections Lead Youth Advocates are successfully reaching out to their peers, advocating for their needs, and acting as peer mentors, they are still facing barriers within their agencies. Until a culture of youth partnership prevails, youth voice will be limited and ineffective at influence policy change.
2. Youth should develop and lead evaluation activities. Evaluation provides a unique and important opportunity for youth to become involved in system of care activities. Since youth have already been recipients of the services of many systems, they are able to determine what research questions evaluators should be asking when determining the success of a program. Involving youth in this aspect also provides a direct route for youth to influence policy decisions and improve the quality of care provided to children and youth within various systems. Additionally, little data currently exists to show the effect of youth voice in systems of care initiatives. By leading the evaluation of their efforts, youth will able to contribute to the national knowledge-base, empirically show the need for youth voice in systems of care, and collect valuable data that can be used to secure youth-specific funding opportunities.
3. The Connections Development Committee should look into additional funding sources that might increase youth participation. Providing transportation and participation stipends could

help combat some of the largest barriers faced by youth at this stage in their organizational development.

Chapter 4: Practice Models- Training and Demonstration Projects

Best practices are treatments and services that are based on scientific evidence. They are used by mental health professionals in real-life settings to meet the needs of children and their families. Wayne County offers a number of best practices to address a spectrum of mental health concerns among children of all ages. These models cover the majority of the individual-level treatment under the umbrella of Connections.

Full Implementation	Training Projects	Demonstration Projects
• Wraparound • Infant Mental Health • Home Based Services • DHS/SED Waiver • Kids Talk CAC	• Multi Family Groups • Parent Management Training: Oregon Model • Trauma Focused Cognitive Behavioral therapy	• Cornerstone (TAYP) • Parent Support Partners • LGBTQ Youth Services

The best practice service models in Wayne County were evaluated by various sites and agencies for the fiscal year 2010-2011. Summaries of service models being evaluated by outside evaluators are presented below, followed by several chapters detailing the evaluations of full-implementation models evaluated by D-WCCHMA.

Training Projects

Adolescent Multi-Family Groups

Description

The Wayne County Adolescent Multi-Family Groups (AMFG) initiative is an adaptation of Family Psychoeducation (FPE), an elaboration of models developed by Carol Anderson, Ian Falloon, Michael Goldstein and William McFarlane. This model was first implemented in programs which serve families of individuals diagnosed with schizophrenia and schizoaffective disorder, however, the model has proven to be helpful for people with bipolar disorder, major depression, obsessive compulsive disorder and borderline personality disorder.

FPE builds on the family's important role in the recovery process of people with mental illness. This approach is for practitioners who want to see markedly better outcomes for consumers by involving

their families or support people. The Wayne County Initiative has made several adaptations to the model to implement it with our youth with mood disorders.

Target Population

Adolescents, ages 12 – 17, who reside in Wayne County and have been diagnosed with a mood disorder; Bipolar disorder, Major Depressive Disorder, and their families.

Desired Outcomes

- Improved clinical outcomes, community functioning and satisfaction for consumers
- Diminished interpersonal strain and stress within families
- Higher rates of employment/school attendance and recovery
- Reduced need for crisis intervention and hospitalization over time
- Improved cost-benefit ratio

Inter-Agency Collaboration

Currently, six agencies in Wayne County are involved in the AMFG initiative.

- Development Centers, Inc.
- Hegira Programs, Inc.
- Northeast Guidance Centers
- Southwest Counseling Solutions
- Starfish Family Services
- The Guidance Center

Consumers Served

Adolescent Multi-Family Groups	
Youth Participants	23
Family Participants	44
All Participants	*77*

Outcomes and Lessons Learned

The AMFG evaluation has been led by Mary Ruffalo, PhD, from the University of Michigan. Based on her findings from the process evaluation described below, a different evidence-based model, Psychotherapy for Children with Bipolar and Depressive Disorders will be used during FY12. This model, developed by Mary Fristad, more accurately fits the issues identified from the project.

Several challenges were faced throughout the implementation of the AMFG groups. Following training by Dr. McFarlane, all participating agencies had low turnout at groups despite extensive outreach efforts. By summer 2010, nearly all groups had dissolved. Based on input from staff acknowledging that many youth were uncomfortable talking with parents/caregivers in a group session, a decision was made to modify the model slightly to allow for more youth engagement.

Workload expectations provided another challenge to AMFG implementation. The AMFG groups were an add-on to most staff and finding time to join with families not on their caseload was difficult. In December 2010, these concerns were noted, and the Project Director/Supervisor worked with each agency to guarantee commitment to AMFG.

By February 2011, there still were no groups operating. The evaluation team conducted interviews with each of the trained staff and key supervisors to explore what the barriers were to initiating new groups. The trained staff were very committed to delivering an AMFG intervention but significant barriers still existed, including, staff turnover, other initiatives that took priority (e.g., TF-CBT training), caseload size, family interest in the intervention and transportation challenges. It was noted by all staff that families had a difficult time engaging in individual and family work and adding a group intervention was often viewed as too much by the families. In spite of these barriers, the trained staff worked hard to get groups going by late April/early May. Three agencies (Development Centers, Inc., Hegira Programs Inc., and Southwest Counseling Solutions) had enough families who committed through the joining process to be a part of this intervention that groups were initiated at each site.

All three agencies offered the workshop sessions but even with reminder calls, offering a meal and providing transportation, only a few of the families who had committed to being a part of the group came to the workshops. The staff continued to do outreach to the families who had indicated interest to encourage them to come to the next sessions. Again, as in Year 1, after a few sessions two of the groups ended and one group had two families still involved.

In the interviews conducted by the evaluation team with youth and parents, it was clear that family members and the youth had a strong commitment to being a part of the intervention but were not able to consistently attend sessions. Some of the families had dropped out of all services, some of the youth were involved in the juvenile justice system and no longer attended individual sessions at the agency, and some just did not attend due to schedule issues/transportation.

Parent Management Training-Oregon Model (PMTO)

Description

Parent Management Training-Oregon Model (PMTO) is a behavior intervention program designed by Dr. Gerald Patterson and colleagues at the Oregon Social Learning Center (OSLC). OSLC is a world renowned research center in the area of antisocial behavior in children. The behavior interventions used in PMTO are based on over 30 years of research on families with children and adolescents who have serious conduct problems. Patterson and his colleagues have identified five core parenting skills that have the most impact on improving serious behavior problems in children.

1. Encouragement: Teaching children new behavior through the use of praise and incentives.
2. Limit Setting: Responding to problem behavior with negative, nonphysical consequences.
3. Monitoring & Supervision: Checking on children's behavior at home and away from home.

4. Family Problem Solving: An organized method of making decisions with family input.
5. Positive Parent Involvement: Parents demonstrating interest, caring and attention.

Training for PMTO is extensive and includes a number of workshops involving active teaching techniques including modeling, video demonstrations, role play, and experiential exercises. Family sessions with trainees are video-recorded and viewed by training mentors who provide detailed coaching to strengthen skills. Practitioners must complete the certification process in order to implement PMTO independently.

To date, three cohorts of practitioners have undergone PMTO training in Wayne County. Of the 38 therapists who began training, 14 were certified to provide services at the end of FY2011. Since the PMTO training initiative began, 138 families attended 4 or more PMTO sessions.

PMTO Training Cohorts 1 -3				
	Cohort 1	Cohort 2	Cohort 3	Total
Number of agency sites for this cohort	6	5	8	19
Number of therapists who began the training	14	13	11	38
Number of therapists who dropped out	10	6	3	19
Number of therapists who have already certified	4	8	2	14
Number of therapists in training who are likely to certify	0	0	6	6
Number of families who attended 4 or more sessions	40	48	50	138

Trauma-Focused Cognitive Behavioral Therapy

Program Description

Trauma Focused- Cognitive Behavioral Therapy (TF-CBT) is an evidence based practice developed by Esther Deblinger, Ph.D., Judith Cohen, M.D., and Anthony Mannarino, Ph.D. to provide services on behalf of children between the ages of 3 and 18, who experienced single or complex trauma. The therapist will provide psycho-education about trauma to the child and identified family members along with skill building strategies.

The TF-CBT model is a sequenced, relationship based approach to services. The aim of TF-CBT is to decrease symptoms of anxiety, depression or other identified behavior problems that stem from a traumatic event. Interventions focus primarily on psycho-education, relaxation techniques, affect regulation, and cognitive coping strategies. Once the child develops additional positive coping skills, the therapist uses desensitization strategies to assist the child in processing the trauma while managing distressing thoughts, feelings and behaviors. Simultaneously, the therapist continues to enhance future safety, parenting skills and family communication (National Child Traumatic Stress Network, 2008).

Target Population
Children between the ages of 3 and 18 who have experienced single or complex trauma.

Desired Outcomes
- Decrease symptoms of anxiety, depression or other identified behavior problems that stem from a traumatic event.
- Assist the child in processing the trauma while managing distressing thoughts, feelings and behaviors
- Enhance future safety, parenting skills and family communication

Inter-Agency Collaboration
There are currently seven provider organizations with TF-CBT programs in Wayne County.
- Starfish Family Services
- The Guidance Center
- The Children's Center
- Northeast Guidance Center
- Southwest Counseling Solutions
- Development Centers, Inc.
- Kids Talk CAC

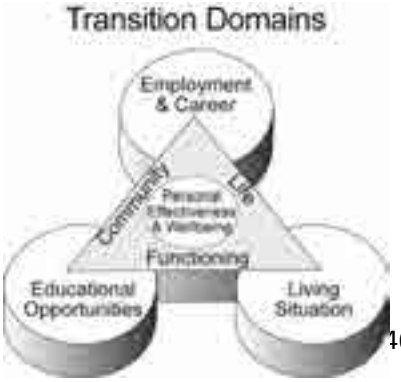
Demonstration Projects

Cornerstone Pilot Project

Program Description
Based on the Transition to Independence Process (TIP) model, the Cornerstone Project is a service model that addresses the needs of youth who are diagnosed with SED and who are in the process of transitioning into adulthood and independence. This is accomplished by not truncating services for children at a predetermined age, but rather, is designed to provide continuous and stable services as youth transition into adulthood based on each of the youth's abilities and preferences that drive the youth's recovery plan until they are able to transition independently into adulthood and adult services. The youth work with an assigned clinician, an assigned peer as well as with the entire Cornerstone team to make gains in five areas of their lives: education, housing stability, employment, mental well- being, and social skills.

Target Population
Transition-age youth, ages 14 – 17, who reside in Wayne County and are diagnosed with SED.

Desired Outcomes
Improvement in five life areas:



- Education
- Housing stability
- Employment
- Health and mental-well being
- Social Skills

Inter-Agency Collaboration

Cornerstone is housed within Southwest Counseling Solutions. Many stakeholders are involved as System of Care partners, including:

- Detroit-Wayne County Community Mental Health Agency
- Michigan Department of Community Health
- Ser Metro-Detroit, Jobs for Progress, Inc.
- CareLink Network

Consumers Served

13 consumers were served during the first three quarters of FY 2011.

Characteristics of Consumers Served

Sex			**Ethnicity**	
Male	8 (62%)		Hispanic	8 (62%)
Female	5 (38%)		African American	5 (38%)
Total	*13*		*Total*	*13*

Outcomes

Anecdotal observational outcomes include:

- Clients who are engaged and responsive have built many strong social relationships with youth in Cornerstone
- Peer mentors have made great contributions in Cornerstone and have been instrumental in helping with recruitment and retention efforts
- Client participation in groups has increased significantly, both in frequency and consistency of attendance

Outcome data is also being collected covering twenty different areas of functioning. Data is currently unavailable; due to the fact that many of the youth have not been enrolled in Cornerstone long enough to calculate change in functioning.

Parent Support Partners

Parents Support Partners (PSPS) provide support and resources to families receiving services within Connections. As parents of children with emotional, behavioral, or other mental health challenges, PSPs

works with the treatment team to enhance the therapeutic process of the clinician by working directly with caregivers to expand, enhance and increase the skills, knowledge and abilities needed to meet the numerous challenges facing families of youth with mental health needs.

The involvement of Parent Support Partners in treatment is well received and has shown positive outcomes. Families feel less isolated and more confident in their ability to care for their child. The unique service model allows for PSPs to use their own personal experiences to empower families, help parents adapt to their situation, navigate systems, and meet their needs.

For FY11, Connections will be working with Family Alliance for Change, the organization providing PSP services, to develop a logic model and evaluation plan.

LGBTQ Services

In 2011, D-WCCMHA partnered with Ruth Ellis Center to provide mental health services to LGBTQ youth. The Ruth Ellis Center provides short and long term residential and support services for runaway, homeless, and at-risk gay, lesbian, bi-attractional, transgender, and questioning youth in Detroit and Southeastern Michigan. Future evaluations will measure the success of these efforts and work to identify unmet needs of this unique population.

Chapter 5: Practice Models- Infant Mental Health

Infant Mental Health (IMH) services follow a relationship-based, home-visitation approach to services. Based on the principle that a healthy parent-infant attachment relationship promotes competent physical, cognitive, social, and emotional development in the infant, IMH services generally involve parent-infant psychotherapy, supportive counseling, developmental guidance, and social and concrete supports[5].

Eight provider agencies delivered IMH services in FY2011: ACCESS, The Children's Center, Development Centers, Inc., The Guidance Center, Lincoln Behavioral Services, Northeast Guidance Center, Starfish Family Services, and Southwest Counseling Solutions.

In addition to its regular Infant Mental Health services, three provider agencies in the D-WCCMHA network participated in a Department of Human Services funded zero to three prevention program for families at risk for child abuse and neglect. Results of this program, called ABC's of Early Childhood, are included in this section. Although program funding ceased at the end of FY11, data collected from this initiative provides valuable insight into the broader Infant Mental Health program. In particular, a satisfaction and outcome survey was distributed to program participants. Responses offer ideas about successful versus unsuccessful program elements for this particular population of consumers, many of which have transitioned into general IMH services.

Research Questions

This evaluation sought to examine the implementation of IMH services in Wayne County and its impact on children and their families. Seven initial research questions were identified.

1. How much and of what type of services are being provided? Are there patterns by age/sex/service provider?
2. What are the characteristics of families being served?
3. Are families satisfied with the services they received?

[5] Weatherston, D. & Tableman, B. (2002). *Infant mental health services: Supporting competencies/reducing risks.* Southgate, MI: Michigan Association for Infant Mental Health.

4. Does involvement result in improvement in key outcome areas: family functioning, child/parent involvement, social and emotional development, parental understanding of development and proper caregiving?

The evaluation team decided to use FY10 to develop a system of data collection and focus on outcomes specific to the child's social, behavioral, and physical functioning. As a result, outcomes related to child/parent attachment, overall family functioning, and parental understanding of child development could not be evaluated in the General IMH population. Self-reported outcomes were collected from satisfaction surveys for the ABCs population. However, previous evaluations of the IMH program have shown positive effects of IMH services in regards to these indicators[6], and future evaluations should include more comprehensive measures.

Data Collection

Two data collection instruments were used to estimate outcomes. The Devereaux Early Childhood Assessments (DECA and DECA/IT) were used to screen for risks in social and emotional development, as well as measure the increase in protective factors throughout the program. The Ages and Stages-3 Questionnaire was used to assess children for developmental delays and alert families to intervention needs. Both instruments are routinely utilized in all Wayne County Infant Mental Health services.

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DECA and DECA I/T

The Devereaux Early Childhood Assessment (DECA) and the Devereaux Early Childhood Assessment for Infants and Toddlers (DECA/IT) are a set of observation tools used to measure protective factors, characteristics of the individual or environment thought to temper the negative effects of stress and lead to positive behavioral and psychological outcomes in at-risk children. Additionally, the DECA instruments are used to screen for risks in social and emotional development, and can be used to measure problem behaviors in older children.

[6] Abbey, J. 2010. Evaluation of Infant Mental Health Services in Wayne County. Ypsilanti, MI: Eastern Michigan University School of Social Work.

Three different forms of the instrument are used with children in Wayne County. The DECA-I, designed for infants 1 to 18 months, has two protective factor scales: Initiative and Attachment/Relationships. The DECA-T, for toddlers 18 to 36 months, has an additional scale for Self-Regulation. The DECA, administered to children 2-5, also has three scales: Initiative, Attachment, and Self-Control. An additional behavioral concern scale measures problem behaviors. All forms have an overall Total Protective Factors score, which is a sum of all sub-scales. This score gives a general idea of the strength of the child's protective factors.

Subscale	**Subscale description**	**Number of Items**		
		DECA-I	**DECA-T**	**DECA**
Initiative	Measures child's ability to use independent thought and actions	18	11	11
Attachment/ Relationship	Measures relationship between child and significant adults, such as parents, family members, and teachers	15	18	8
Self-Regulation	Measures child's ability to gain control of and manage emotions, and sustain focus and attention		7	
Self-Control	Measures child's ability to experience a range of feelings and express them using words and actions that society considers appropriate			8
Behavioral Concerns	Measures behaviors that become problematic when they occur in excess and can interfere with developmental tasks, cause adjustment problems, or cause anxiety and worry for parents or teacher			10

Scoring and Interpretation

Depending on the situation, the DECA is completed by the parent, teacher, or clinician. Raters complete a checklist indicating how often they have seen the child performing behaviors over the last month (0=rarely, 1=occasionally, 2=frequently, 4=very frequently). Raw scores are calculated by adding the subscales, and are converted into percentiles and t-scores for interpretation. Based on the t-score, scores are classified as Area of Need, Typical, and Strength.

Assumptions

- The correct form (DECA-I, DECA-T, DECA) is being used.
- For DECA-I, the correct Individual Scoring Profile is being used based on the age of the infant.
- The Parent Scoring is being used when the parent is the rater; the Teacher Scoring is used when a clinician or other is the rater.
- The same caregiver had completed both the pre and post forms.

Ages and Stages Questionnaire

The Ages and Stages Questionnaire is a parent-completed assessment designed to screen for developmental delays. Each scale is age-appropriate and includes items that represent behaviors a child should be able to perform at each specific age. Five domains of development are assessed: communication, gross motor skills, fine motor skills, problem solving, and personal-social skills. A score for each domain is calculated based on the following: 10 points for "Yes", 5 points for "Sometimes" and 0 points for "Not yet". A child is identified as in need of developmental intervention if the score is lower than the cutoff, which is set at two standard deviations below the mean.

ABC's of Early Childhood Satisfaction/Outcome Survey

A Satisfaction/Outcome Survey was distributed for participants in the ABC's of Early Childhood program. Designed with input from the three participating agencies, the survey was a three page questionnaire developed to measure program satisfaction and perceived impact of the program on family life. The survey was completed by the primary caregiver in the summer of 2011. Families received an age-appropriate book for completing the questionnaire, which was provided to the families in a sealed envelope by the home visitor. For families who had already ended their participation in the program, the survey was sent by mail to the last known address. The overall response rate for the survey was 30.11%. This rate is actually considerably high, considering 60% of surveys mailed to families were returned to sender. Additionally, by the time the surveys were distributed in the summer of 2011, participating agencies knew that funding for this program would end at the close of the fiscal year. By summer, agencies were already making transition plans for families and staff, which might have also influenced the response rate.

ABC's of Early Childhood Outcome/Satisfaction Survey Response Rate by Agency			
Agency	**Surveys Received**	**Families Served**	**Rate**
Development Centers, Inc.	20	62	32.26%
Starfish Family Services	10	51	19.61%
The Guidance Center	25	73	34.24%
Total	*56*	*186*	*30.11%*

Findings

1) How much and what type of services are being provided?

General Infant Mental Health

A total of 584 families received Infant Mental Health services.

Families Served by Agency

Infant Mental Health: Families Served		
Agency	**No. Families**	**Percent of Total**
Arab American and Chaldean Council	16	2.7%
Development Centers Inc.	79	13.5%
Lincoln Behavioral Services	18	3.7%
Northeast Guidance Center	60	10.3%
Southwest Counseling Solutions	47	8%
Starfish Family Services	50	10.2%
The Children's Center	96	16.4%
The Guidance Center	218	37.3%
Total	**584**	**100.0%**

Services Received

Detailed information regarding the components of service delivery was not collected. However, Infant Mental Health (IMH) involves frequent home visits to provide services.

Length of Stay

Between October 1, 2010 and September 30, 2011, 351 of the 584 cases closed. For all closed cases, regardless of if the case was opened under the child or the parent, the average length of stay was 332 days. Cases may have been opened under the parent because the parent began services before the child was born, or due to general practices of clinicians. Cases opened under the child had a slightly higher length of stay, 351.9 days.

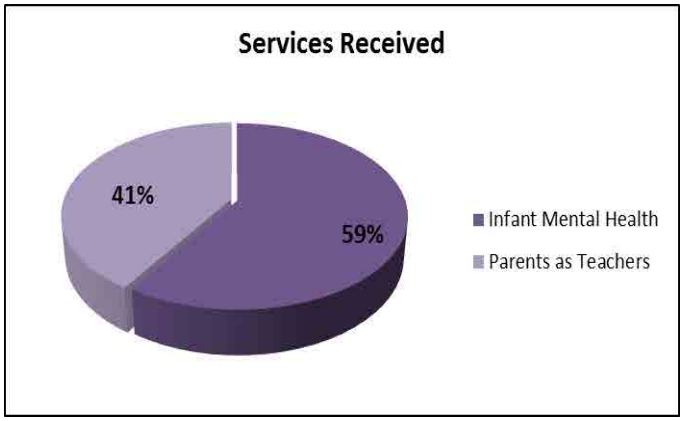
Infant Mental Health: Length of Stay (Days)				
	N	Min	Max	Average
Case opened under parent	88	0	1808	270.7
Case opened under child	263	0	1549	351.9
All cases	351	0	1008	331.5

ABC's of Early Childhood

186 families were involved in the ABC's program.

Program Type

Families received services that followed the Infant Mental Health model or the Parents as Teachers model. The Infant Mental Health model was more prevalent at all participating agencies, with 59% of all families receiving Infant Mental Health services.



Activities

All families received regular home visits where they received Infant Mental Health or Parents as Teachers services. The number of visits each family received per month varied by need and the service model the family was receiving. Additionally, families were invited to attend outside activities such as family-based events, playgroups, and infant massage classes.

ABC's Activity Involvement	
Activity	**Participation**
Home Visits	100%
Family Events	10.7%
Groups (such as playgroups, infant massage, etc.)	14.3%

Family Fun Night

An ABC's-specific family fun night was held in March of 2011 that provided an opportunity for parents to connect while their children played together. Due in part to lack of transportation to the location and other unexpected circumstances, turnout to the event was low. Two families attended with seven children (four teenagers, two aged 0-3 and 1 aged 4-6). Several lessons were learned from the event, including: the need to deal with transportation problems, the need for activities for older children, and

the possibility of holding events at different times and locations. The families in attendance reported satisfaction with the event and satisfaction with their experience in the ABC's program up to that point.

Safety, Health, and Hygiene
In addition to providing parent-infant services, the ABC's program assessed families and homes for unmet needs related to safety, health, and hygiene, and provided referrals when appropriate. When a need was identified, staff helped connect families to community resources. In all cases where referrals were made, follow-up contact was made to guarantee the participants were receiving the services in question.

Patterns by Age/Sex/Service Provider
No significant patterns were found by comparing the services received across program type, age, sex, and service provider.

2) What are the characteristics of families being served?

General Infant Mental Health
Child age, sex, and race are described below. Data was not available for 160 cases which were open under the parent.

Age
Children entered IMH services at an average age of 20 months.

Age of Child	Percentage
"Pre-birth" – 1 month	2.0%
1 – 6 months	12.7%
6 – 12 months	16.4%
12 – 18 months	10.8%
18 – 24 months	33.7%
24 – 36 months	15.6%
36+ months	8.8%

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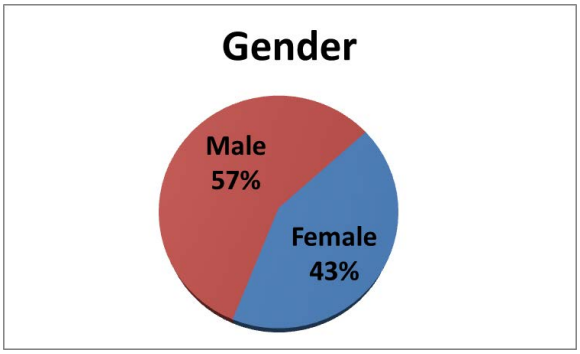
Sex

Children receiving IMH services were more frequently male (57%) than female (43%). Male children entered slightly services later than female children, averaging 21 months at entry compared to 18 months for females. Males also stayed in services an average of 30 days less than females.



Ethnicity

Children receiving IMH services were more frequently male (57%) than female (43%). Male children en

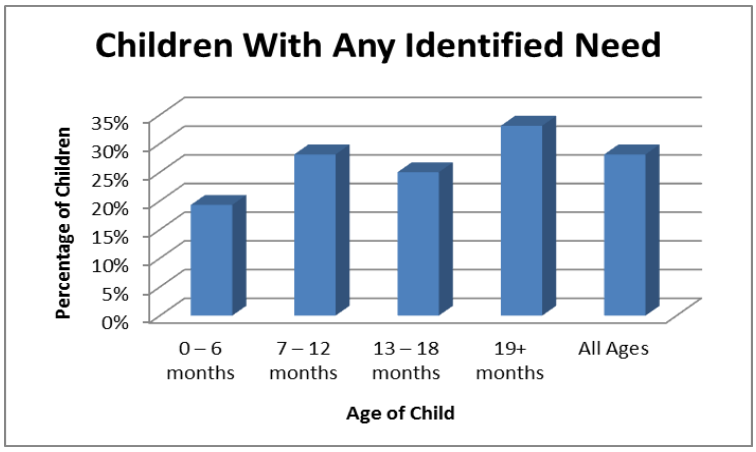
Ethnicity	
Native American/Alaskan Native	0.5%
African American	21.2%
Hispanic or Latino	4.7%
Multiracial	7.1%
Other	0.2%
White (European Descent)	26.2%

Developmental Concerns

The Ages and Stages Questionnaire was the instrument used during IMH services to detect developmental needs and monitor progress. The results provide important information regarding the developmental status of program participants. Overall, 28.1% of children had at least one area of need at the initial assessment. As described previously, a child is considered "at need" if their score falls below two standard deviations of the standardized mean.

The Ages and Stages Questionnaire focuses on five domains of child development: Communication Skills, Gross Motor Skills, Fine Motor Skills, Problem Solving Skills, and Personal-Social skills. The highest needs were Communication Skills and Problem Solving Skills. Developmental needs varied by age group, and the need for Communication Skills increased with age. Overall, needs were highest among children 7 – 12 months and 19+ months.

Percent of Children with Developmental Needs by Subscale					
Subscale Name	**0 – 6 months**	**7 – 12 months**	**13 – 18 months**	**19+ months**	**Total**
N	**52**	**57**	**44**	**124**	**277**
Communication Skills	3.8%	3.5%	11.4%	19%	11.7%
Gross Motor Skills	3.8%	10.5%	4.5%	5.0%	5.8%
Fine Motor Skills	3.8%	12.3%	11.4%	10.7%	9.9%
Problem Solving Skills	3.8%	14.0%	6.8%	14.9%	11.3%
Personal-Social Skills	9.6%	5.3%	6.8%	10.7%	8.8%
Total	19.3%	28.1%	25.0%	33.1%	28.1%

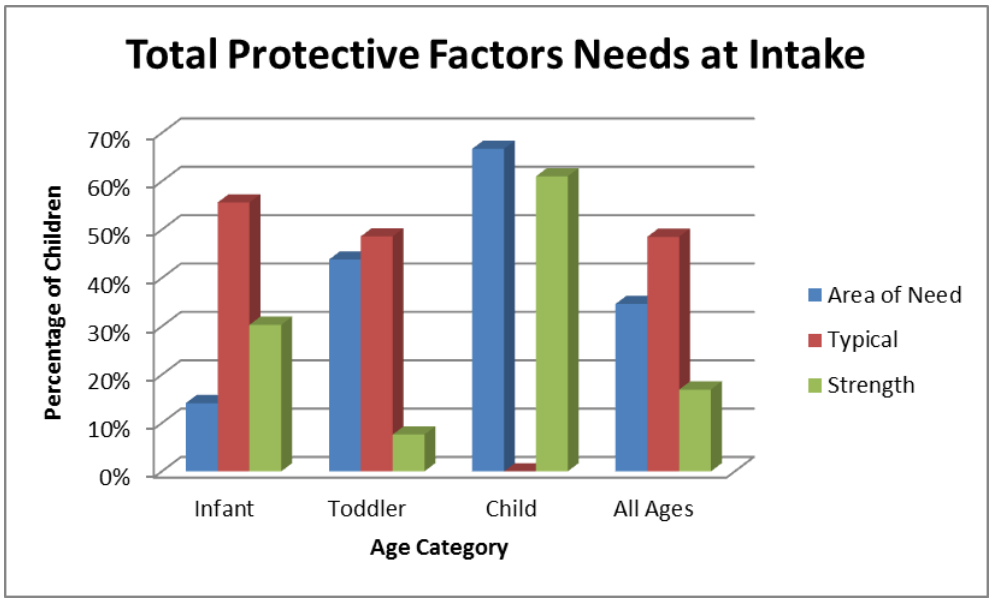


Social and Emotional Concerns

The Deveraeux Early Childhood Assessment series were used to assess protective factors (characteristics of the individual or environment thought to temper the negative effects of stress and lead to positive behavioral and psychological outcomes in at-risk children) and screen for social and emotional developmental concerns. Scores are normalized for age groups, and are categorized as Area of Need (0 - 18th percentile), Typical (18th – 82nd percentile), and Strength (above 82nd percentile).

DECAs were available for 237 participating children. The Total Protective Factors score gives a general overview of the child's status and social and emotional needs. Overall, 34% of children fell into the "Area of Need" category for their Total Protective Factors. Problems appear to increase with age, likely because children have had more time to develop problems. This finding supports the need for intervention at the earliest age possible in order to prevent future social and emotional concerns.

DECA Total Protective Factors by Age Group at Intake			
DECA Form	**Area of Need**	**Typical**	**Strength**
Infant	14.1%	55.6%	30.3%
Toddler	43.8%	48.6%	7.6%
Child	66.7%	27.3$	61.%
All Ages	34.6%	48.5%	16.9%



In addition to Total Protective Factors, each DECA form allows for individual subscale scores to be examined. For a detailed description of the subscales, see DECA instrument description earlier in this document. Each score is standardized by the child's age and the person completing the form (parent or teacher/therapist). The tables below show that although the average T scores for children in each subscale. Scores decrease by age regardless of the scale, indicating an increased need among older children and the potential for younger children to maintain or increase their total protective factors throughout IMH services.

DECA Infant: Average Subscale Scores at Intake			
Subscale	**Average T Score**	**Range**	**Interpretation**
Initiative	54.18	6 – 89	Typical
Attachment/Relationship	55.02	31 – 72	Typical
Total Protective Factors	54.18	6 – 89	Typical

DECA Toddler: Average Subscale Scores at Intake			
Subscale	**Average T Score**	**Range**	**Interpretation**
Initiative	44.55	28 – 72	Typical
Attachment/Relationship	46.10	28 – 66	Typical
Self-Regulation	41.27	21 – 72	Area of Need
Total Protective Factors	42.93	12 - 88	Typical

DECA Child: Average Subscale Scores at Intake			
Subscale	**Average T Score**	**Range**	**Interpretation**
Initiative	40.03	28 – 69	Area of Need
Attachment/Relationship	41.36	28 – 72	Typical
Self-Control	39.73	28 – 64	Area of Need
Behavioral Concerns*	65.56	45 – 75	Typical
Total Protective Factors	37.50	20 – 64	Area of Need

*The Behavioral Concern scale is inverted- a higher score indicates a higher level of need.

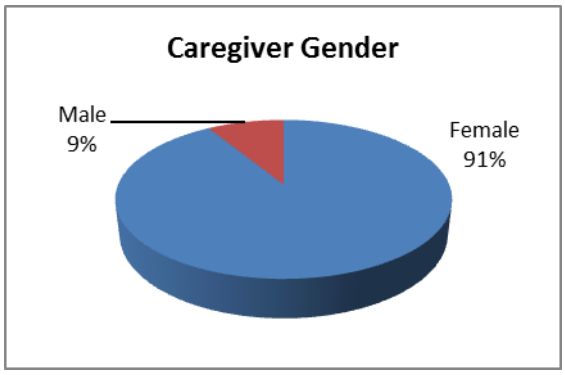
ABC's of Early Childhood

Caregivers

99.2% of primary caregivers identified themselves as the birth parent of the child receiving services. In the 26.2% of cases where a second guardian was involved with the program, 23.8% identified as the other birth parent, 0.4% identified as the grandparent or great-grandparent, and 2% noted "other."

Demographics

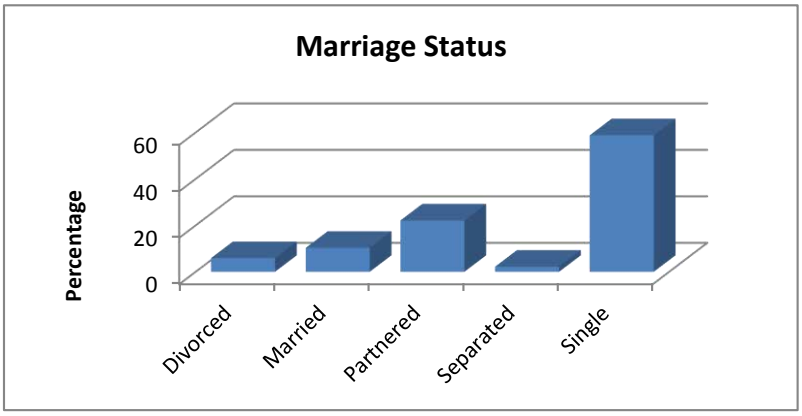
Caregiver age, gender, and ethnicity are described below. The mean age of caregiver was 26 years old, with caregivers ranging from 13 to 42 years old. Approximately 9/10 caregivers were female, and the majority defined their race/ethnicity as either White (European descent) or African American.

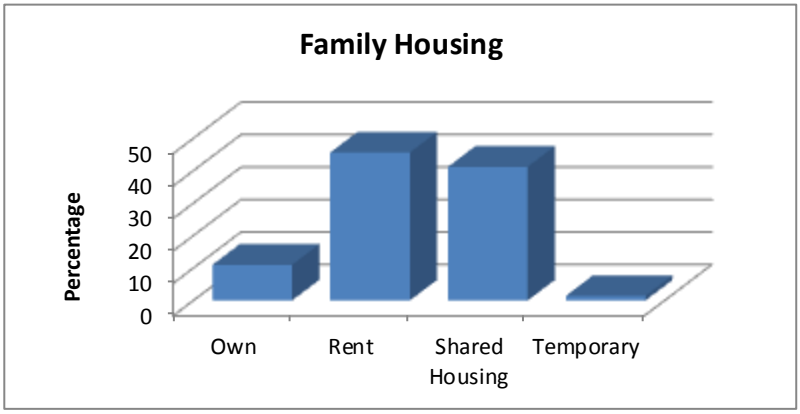


Ethnicity	
Native American/Alaskan Native	1.5%
African American	30.1%
Hispanic or Latino	2.2%
Middle Eastern/ Arab/Chaldean	1.5%
Multiracial	0.7%
Other	2.2%
White (European Descent)	61.1%

Family Status

Most caregivers were unmarried, either single or partnered. Renting and sharing housing with relatives or friends were the most common living situation for caregivers, and 1.4% of families were living in temporary housing (either at a shelter or with friends).

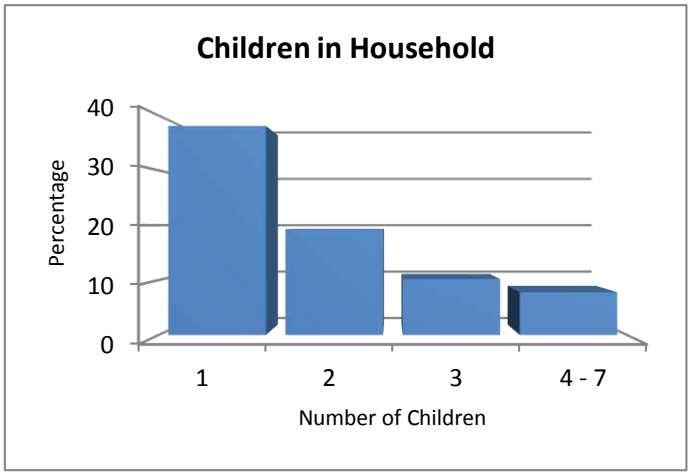




Family Size

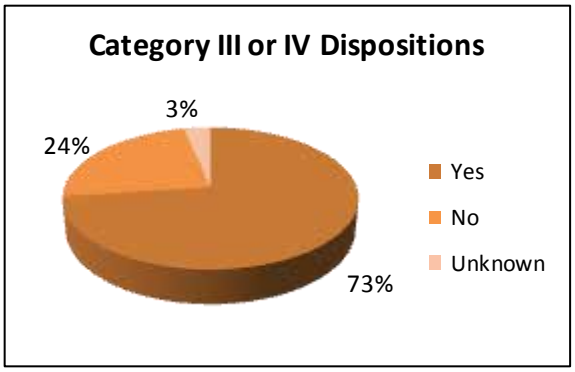
Family size varied greatly among children in the ABC's program and ranged from 1 person to 9 people in the household. (It is expected that the 1.1% of participants who indicated that they were the sole person in the household could be included into the group with a family size of 2, since all participants were a caregiver/child pair.) The average family size was 3.3 persons, with an average number of 1.9 children in the household (range of 1 – 7 children).

In approximately 40% of cases, the child receiving services in the ABC's program was the only child in the household. This is promising, as it indicates that families are were referred to the ABC's program most often with their first child. Families have the ability to gain knowledge and acquire skills that will benefit them if additional children are added to the family in the future.



CPS Involvement

The majority of parents (73%) had Child Protective Services Category III or IV dispositions, which resulted in their referral to ABC's. To participate in the program, families had to have been identified as "at-risk" by CPS with a Category III or IV disposition. They could not have a Category I or Category II disposition. Although most families were referred from the local CPS offices, community referrals were also accepted. Community referrals were most frequent during the early stages of the project.



Children

A total of 233 children received services from the ABC's program. Characteristics of the children served, including both demographic and behavioral assessment information, are presented below.

Age

The mean child age was 15 months, although 48.7% of children were under 12 months when they began the program. In fact, 35.5% of children were under 6 months of age.

Age of Child	Percentage
"Pre-birth" – 1 month	19.8%
1 – 6 months	15.7%
6 – 12 months	13.2%
12 – 18 months	8.3%
18 – 24 months	10.7%
24 – 36 months	10.3%

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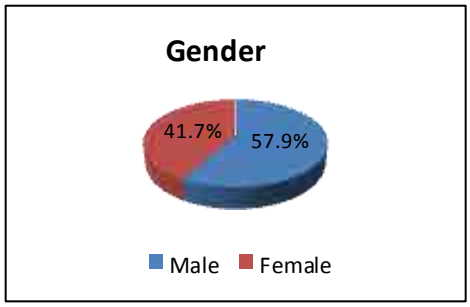
Gender

Male children represented nearly 6/10 clients served in the ABC's program. Female children were slightly more likely (2.3%) than male children to be enrolled in Infant Mental Health services than Parents as Teachers.



Ethnicity

Ethnicity	
African American	31.8%
Hispanic or Latino	0.4%
Middle Eastern/ Arab/Chaldean	1.7%
Multi-Racial	16.1%
Other	0.4%
White (European Descent)	49.6%

Developmental Concerns

The Ages and Stages Questionnaire was the instrument used in the ABC's program to detect developmental needs and monitor progress. The results provide important information regarding the developmental status of program participants. Overall, 24.3% of children had at least one area of need at the initial assessment. Among those with needs, 24% had needs noted on multiple domains. As described previously, a child is considered "at need" if their score falls below two standard deviations of the standardized mean.

The Ages and Stages Questionnaire focuses on five domains of child development: Communication Skills, Gross Motor Skills, Fine Motor Skills, Problem Solving Skills, and Personal-Social skills. The highest need was seen in the Fine Motor domain, with 12.1% of children identified as in need of intervention. Developmental needs varied by age group. Overall, needs were highest among children 7 – 12 months and 19+ months (each group had 9.3% of children with needs identified on one or more subscales.) Percentages below reflect the proportion of children with needs in each domain.

ASQ-3 Developmental Needs by Age					
Subscale Name	**0 – 6 months**	**7 – 12 months**	**13 – 18 months**	**19+ months**	**Total**
Communication Skills	0.9%	0.9%	0	3.7%	5.6%
Gross Motor Skills	0.9%	3.7%	0	1.9%	6.5%
Fine Motor Skills	2.8%	4.7%	0.9%	3.7%	12.1%
Problem Solving Skills	1.9%	2.8%	1.9%	2.8%	9.3%
Personal-Social Skills	1.9%	0	0	0	1.9%

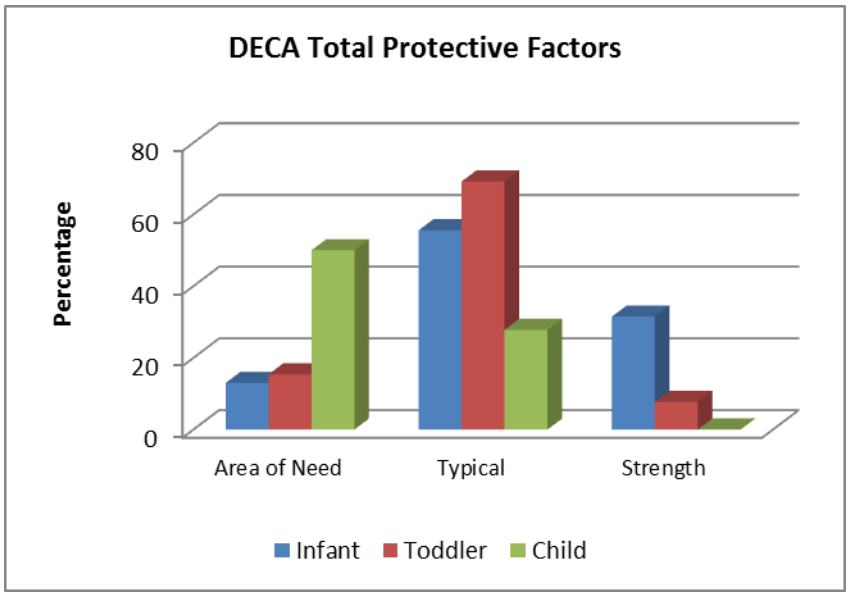
Social and Emotional Concerns

The Deveraeux Early Childhood Assessment series were used to assess protective factors (characteristics of the individual or environment thought to temper the negative effects of stress and lead to positive behavioral and psychological outcomes in at-risk children) and screen for social and emotional developmental concerns. Scores are normalized for age groups, and are categorized as Area of Need (0 - 18th percentile), Typical (18th – 82nd percentile), and Strength (above 82nd percentile).

DECAs were available for 84 out of 233 participating children. The DECA is currently being incorporated into services throughout Wayne County as a standard assessment. Although the majority (63.1%) were DECA for Infants, 15.5% completed the DECA for Toddlers and 21.4% completed the DECA for Children. Due to the standardization of the DECA, scores can be compared across the ages.

The Total Protective Factors score gives a general overview of the child's status and social and emotional needs. Overall, most children fell into the "Typical" category for their Total Protective Factors. Total Protective Factors increases with age, indicating that the level of need increases as children get older. This finding parallels results for children involved in General Infant Mental Health programs in Wayne

County, and supports the need for intervention at the earliest age possible in order to prevent future social and emotional concerns.



DECA Total Protective Factors by Age Group			
DECA Form	**Area of Need**	**Typical**	**Strength**
Infant	13.2%	56.6%	30.2%
Toddler	15.4%	76.9%	7.7%
Child	50.0%	38.9%	11.1%

In addition to Total Protective Factors, each DECA form allows for individual subscale scores to be examined. For a detailed description of the subscales, see DECA instrument description earlier in this document. The tables below show that although the average scores for children in the ABC's of Early Childhood program fall in the "Typical" range, the average scores decrease with age.

DECA Infant: Average Subscale Scores			
Subscale	**Average Score**	**Range**	**Interpretation**
Initiative	55.30	37 – 89	Typical
Attachment/Relationship	55.92	32 – 67	Typical
Total Protective Factors	52.89	20 – 84	Typical

DECA Toddler: Average Subscale Scores			
Subscale	**Average Score**	**Range**	**Interpretation**
Initiative	54.77	38 – 66	Typical
Attachment/Relationship	52.00	35 – 66	Typical
Self-Regulation	47.25	32 – 70	Typical
Total Protective Factors	50.54	33 – 69	Typical

DECA Child: Average Subscale Scores			
Subscale	**Average Score**	**Range**	**Interpretation**
Initiative	46.11	28 – 69	Typical
Attachment/Relationship	43.89	28 – 72	Typical
Self-Control	41.65	25 – 70	Area of Need
Behavioral Concerns*	58.80	42 – 72	Typical
Total Protective Factors	41.72	28 – 70	Area of Need

*The Behavioral Concern scale is inverted- a higher score indicates a higher level of need.

3) Are families satisfied with the services they receive?

General Infant Mental Health

Satisfaction details were not collected for general IMH services, however, results from the ABC's of Early Childhood described below suggest an overall positive experience with IMH services.

ABC's of Early Childhood

Satisfaction measures were used for the ABC's of Early Childhood population only. Caregivers reported satisfaction with the services they received and were likely to recommend the program to other families in need. Families with the youngest children (0 – 6 months) reported being the most satisfied with services, with satisfaction decreasing slightly with the child's age. Similarly, most caregivers seemed satisfied with the number of visits they received, and those with the youngest children were the most likely to desire more frequent visits.

ABC's: Self-Reported Program Satisfaction					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Things taught in the program fit my family.	58.9% (33)	28.6% (16)	10.7% (6)	1.8% (1)	0%
My home visitor treated me with respect.	91.1% (51)	8.9% (5)	0%	0%	0%
My home visitor helped me meet the needs of my family.	67.9% (38)	26.8% (15)	3.6% (2)	1.8% (1)	0%
I am using what I learned in the program at home.	71.4% (40)	21.4% (12)	7.1% (4)	0%	0%
Being in this program was not difficult for my family.	67.9% (38)	23.2% (13)	3.6% (2)	3.6% (2)	0%
I would have liked more frequent home visits.	23.2% (13)	16.1% (9)	46.4% (26)	8.9% (5)	1.85 (1)
I found family events and group activities to be helpful. Did not attend groups: 66.1% (37)	19.6% (11)	10.7% (6)	1.8% (1)	1.8% (1)	0%
I would recommend this program to other parents	73.2% (41)	23.2% (13)	1.8% (1)	1.8% (1)	0%
I am satisfied with my experience in ABC's	76.8% (43)	16.1% (9)	1.8% (1)	3.6% (2)	1.8% (1)

Several open-ended questions on the Satisfaction/Outcome Survey provided additional insight into caregiver experiences with the program.

<u>What was helpful?</u>

Caregivers were asked if there were any specific ways that ABC's has helped or hurt their family. Many described the program as aiding in the development of their child, supporting the caregivers, and helping to find resources for the family.

Some caregivers described their experiences:

> "*It has helped us to be able to identify more with her (child's) feelings and meet her needs and understand them better."*
>
> *"My therapist is very helpful with services she has provided my family with. She has come out when I needed extra help."*
>
> *"This program has opened the door to a lot of different programs for our children's growth and well-being."*

What was liked best

When asked what the caregivers liked best, many highlighted traits of the program and its employees as being respectful and encouraging. They mentioned learning much from the program, and the home visits were extremely significant.

Caregivers responded with:

> *"The supervisor we had was very nice and respectful and helped me understand a lot about how to discipline my daughter properly, how to encourage and what to encourage...also how to explain things to my daughter in ways she'd understand."*
>
> *"All of the learning equipment that the home visitor has brought out to the house has my son wanting to learn more."*
>
> *"The in-home visit and the hands-on approach. All the info about our child's needs and how they can be met. Also, having a better understanding of how to try and have a healthy family."*
>
> *"The home visitor was great! From day one, she made me feel 100% comfortable with her. My daughter loves playing with her and she's given me so much knowledge."*

What was liked least and what could be more useful

Many caregivers responded saying that they could use more frequent home visits and the amount of funds for the program was a concern. Another caregiver stated that the program wasn't useful to him or her.

Caregivers stated:

> *"Spend more time with clients and show them the places they need to go and brighten ideas for new parents to try, like more activities."*
>
> *"Please keep giving information on resources. We are struggling, like so many others."*
>
> *"I did not find it useful to sit for nearly an hour and really do nothing. The program should provide more interaction, using client goals and ways to pursue them. I have not been very happy. I can't come to groups at your location. I go to Tote in Woodhaven. They won't let me go on field trips if I don't go to their groups."*

4) Does involvement result in improvement in key outcome areas?

General Infant Mental Health

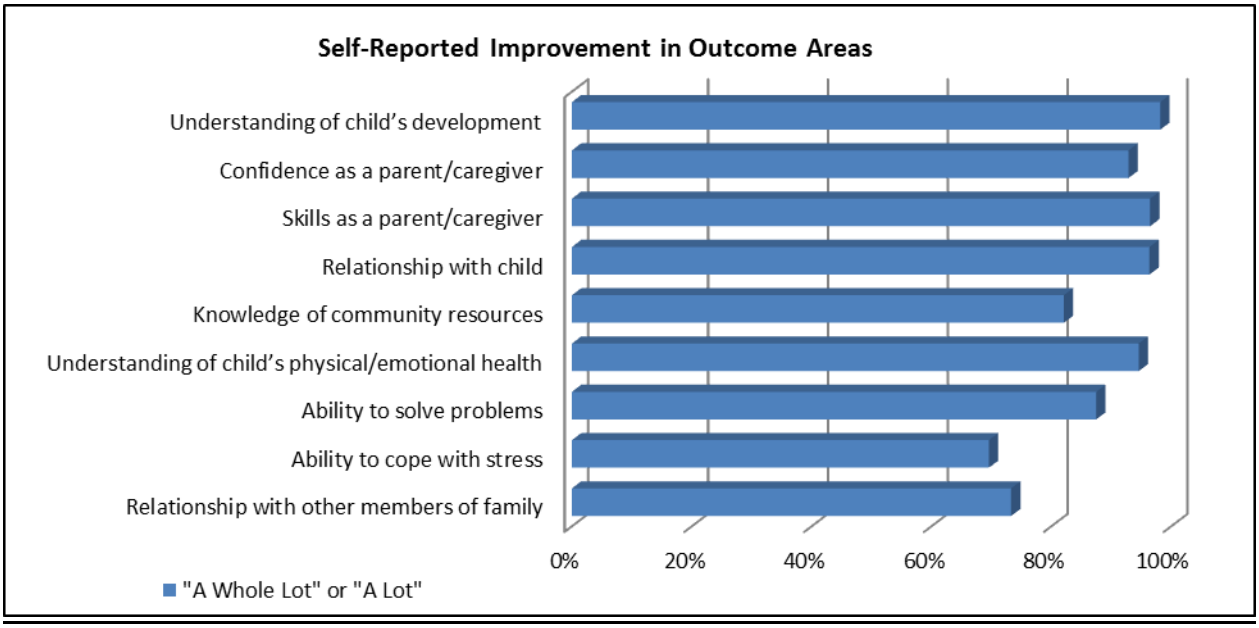
Improvement in social and emotional development was to be measured by comparing pre- and post-DECA scores. Since Wayne County was rolling out the universal practice of using the DECA during this year, data was available for only 12 cases. This data is not presented in this report.

ABC's of Early Childhood

Initially, ABC's planned to measure the change in social and emotional development by comparing pre- and post- DECA and Protective Factors Survey scores. Unfortunately, due to the unexpectedly high dropout rate and the eventual ending of the program, post- scores were only available for a handful of children. As a result, self-reported outcomes from the Satisfaction/Outcome Survey were used to estimate program outcomes.

Self-reported outcomes are positive. Over 90% of survey respondents indicated that involvement in the ABC's program increased their understanding of their child's development, increased their confidence as a caregiver, improved their skills as a caregiver, improved their relationship with their child, and increased their understanding of their child's physical and emotional health needs either "a whole lot" or "a lot". Only 69% of caregivers felt the program helped with their ability to cope with stress "a whole lot" or "a lot", suggesting that future programs should target parental stress reduction strategies.

Self-Reported Improvement in Core Outcome Areas					
	A whole lot	A lot	A little	Very little	Not at all
Caregiver's understanding of child's development	73.2% (41)	25.0% (14)	0%	1.8% (1)	0%
Confidence as a parent/caregiver	66.1% (37)	26.8% (15)	3.6% (2)	1.8% (1)	0%
Skills as a parent/caregiver	66.1% (37)	30.4% (17)	1.8% (1)	1.8% (1)	0%
Relationship with child	71.4% (40)	25% (14)	1.8% (1)	1.8% (1)	0%
Knowledge of community resources	50% (28)	32.1% (18)	17.9% (10)	0%	0%
Caregiver's understanding of child's physical and emotional health needs	69.6% (39)	25% (14)	3.6% (2)	1.8% (1)	0%
Caregiver's ability to solve problems	55.4% (31)	32.1% (18)	10.7% (6)	1.8% (1)	0%
Caregiver's ability to cope with stress	44.6% (25)	25% (14)	26.8% (15)	1.8% (1)	1.8% (1)
Caregiver's relationship with other members of family	42.9% (24)	30.4% (17)	19.6% (11)	3.6% (2)	3.6% (2)



Program Exit

Among the approximately 46% of program participants that exited the program during the year, only 11.8% completed services or transitioned to other services.

Reasons for Exit	
Completed Services	3.9%
Dropped Out	32.3%
Loss of Contact	40.9%
Moved/Relocated	6.3%
Transitioned to Other Services	7.8%
Didn't Want to Change Home Visitor	6.3%
Other	2.4%

Summary and Recommendations

Home-visitation zero to three secondary prevention programs have historically been shown to be an effective method for preventing child abuse and neglect, increasing parent-infant attachment, and promoting social and emotional development.

ABC's Recommendations

1. Secondary Prevention programs are essential and require continued funding and support. Scores on both the ASQ and the DECA assessments indicate that older children enter programs with more developmental, social, and emotional issues. Targeting at-risk families while children are infants is important to stabilize families, improve parent-infant attachment, and reduce the risk of future childhood problems.
2. Long-term outcomes must be measured to determine program success. At its core, the ABC's of Early Childhood program is a prevention program, where the true outcomes will be measured in the child and families' success in the future. 73% of caregivers had a CPS III or IV disposition at the time of referral, and 40% of families received a referral to ABC's for their first child. Follow-up studies should look into future CPS violations for families, as well as examine the effect of program model and length of stay on future violations.
3. An Infant Mental Health model might be more appropriate for this population. Staff members agreed that many families were in crisis and in need of basic supports, making it challenging to keep them engaged in Parents as Teachers activities. Additionally, caregivers reported that the program had the least impact on their ability to solve problems, ability to cope with stress, and their relationship with other members of their families. An Infant Mental Health approach might be more appropriate for helping families deal with these concerns, as the model allows for more frequent contact and more therapeutic-based services.
4. Future programs involving this population must be cautious of the probable dropout rate and employ strategies to guarantee family retention. In the ABC's program, the highest dropout rate was found in families who had been enrolled in the program less than 3 months. This supports staff anecdotes indicating that they do not have enough time to develop relationships before the family drops out. Additionally, the transient nature of this particular population makes them especially vulnerable to losing contact. During the initial treatment planning, staff and families should develop a plan for reaching the family if they are forced to relocate, lose access to a phone, etc.

General IMH Recommendations

1. A comprehensive evaluation plan must be developed to study all aspects of the Infant Mental Health services. A workgroup composed of stakeholders, leaders in the field, and evaluators from past evaluations should work together to develop a way to establish indicators of program success, track data over time, and follow-up with families to determine the long-term effects of this prevention program.

Chapter 6: Wraparound

Wraparound is an intensive, individualized care planning and management process for youth with complex needs. The process involves team-based treatment planning that is driven by the family and youth. During the process, a team of individuals including the youth, family members, friends, community members, mental health professionals, and anyone else deemed important by the family works together to develop, implement, and monitor and individualized plan of care. The formal Wraparound plan often includes formal services as well as community and social support, and the team works together to monitor outcomes over time. Wraparound has been implemented throughout the United States, and has been shown to decrease residential treatment, increase use of community-based care, and be supported by youth and families involved.

Eight provider agencies were involved in the CMH Wraparound program in FY2011.

- Black Family Development, Inc.
- Development Centers, Inc.
- Hegira Programs, Inc.
- Northeast Guidance Centers
- Southwest Counseling Solutions
- Starfish Family Services
- The Children's Center
- The Guidance Center

Research Questions

The current FY11 Wraparound evaluation sought to examine the implementation of the Wraparound program and its impact on SED children and their families. The following questions were developed collaboratively with the Wraparound Program Supervisors and the Evaluation Subcommittee to guide the evaluation:

1. How much and what type of services are being provided? Are there patterns by age/sex/service provider?
2. Is the Wraparound process effectively being implemented as it was intended?
3. Are families satisfied with the Wraparound program?
4. Does involvement in Wraparound result in improved functioning for youth?

Data Collection

A centralized database was developed to compile and track the progress of children and youth enrolled in Wraparound. This database includes demographic and encounter information from the Wayne County Mental Health Wellness Information Network (MHWIN), satisfaction and fidelity indicators from self-report surveys, and functioning outcomes from Family Status Reports.

Family Status Report

The Family Status Report (FSR) is a comprehensive form completed every three months by the Wraparound facilitator. The FSR collects information about living status, functioning, criminal conduct, child welfare investigation reporting, education information, resiliency indicators, and safety indicators. Two forms are used, one for ages 4-6 and another for ages 7-18. The FSR is also used to track services received.

CAFAS/PECFAS

Child & Adolescent Functional Assessment Scale (CAFAS) and Preschool & Early Childhood Functional Assessment Scale (PECFAS) were the assessments used to measure the youth's functioning across critical life domains and to determine functional improvements over time. The CAFAS and PECFAS are completed by trained practitioners based on information from clinical evaluations at three month intervals. The CAFAS, intended for youth age 7-17, covers eight domains: school, home, community, behavior toward others, moods/emotions, self-harmful behavior, substance abuse, and thinking problems. The PECFAS, intended for youth 3-7 is the preschool version of the CAFAS, and includes seven subscales: school/preschool/daycare, home, community, behavior toward others, moods/emotions, self-harmful behavior, and thinking/communication. Since only one PECFAS was completed for a Wraparound consumer, PEFCAS results are not reported here.

Satisfaction and Fidelity Surveys

The Wraparound Satisfaction and Fidelity Survey were administered to caregivers at six month intervals and/or graduation. A shorter, adapted version was also administered to youth participants. To ensure confidentiality, facilitators delivered the surveys to the family and asked them to return the completed instrument in a sealed envelope. The surveys asked about satisfaction with the Wraparound process, the facilitator, and the quality of additional services received. Fidelity measures were adapted from the Michigan Wraparound Inventory Fidelity Instrument (M-WIFI) and grouped based on the 10 core principles of Wraparound.

Findings

Characteristics of Program Participants at Intake

Demographics

Approximately 424 children/youth received Wraparound services in 2010. The majority of youth were age 10-18, and approximately 60% were male. Diagnoses and demographics were collected from the county-based Mental Health and Wellness Information Network (MH-WIN). Approximately 70% of Wraparound consumers had a primary diagnosis of either a behavioral disorder or a mood disorder. Slightly more than half were age 15 – 18.

Age of Child/Youth	
6 – 9	10.6%
10 – 14	33.7%
15 – 18	50.7%

Gender of Child/Youth		
	Frequency	**Percentage**
Male	243	57.3%
Female	160	37.7%

Ethnicity of Child/Youth		
	Frequency	**Percentage**
Black/African American	231	54.5%
White/Caucasian	102	24.1%
Some other Race	23	5.4%
Unknown Race	10	2.4%
Not specified	57	13.5%

Diagnosis Category	
Behavioral Disorder (ADHD, ODD, Conduct, etc.)	39.8%
Mood Disorder (Depression, anxiety, etc.)	25.6%
Thought Disorder (Psychosis, Schizophrenia, etc.)	6.5%
Other (PTSD, Adjustment disorders, Substance Disorders, etc.)	6.5%

Age When Child/Youth Began Wraparound		
	Frequency	**Percentage**
Younger than 12	94	23.3%
12, 13, or 14	94	23.3%
15,16, or 17	215	53.3%

Living Status

Living status at intake was collected on the Family Status Report, and reflected the living situation in the previous 30 days. Additionally, 6.6% (19) youth had multiple placements in the thirty days prior to intake. 6 (1.7%) were in an inpatient hospitalization facility, either in the psychiatric unit or the crisis stabilization unit, and the remaining were with family friends, in temporary or permanent foster care, or in an emergency shelter.

Primary Living Status at Intake		
	Frequency	**Percentage**
Home of birth parent	198	68.3%
Home of adoptive parent	18	6.2%
Living w/relative or family friend	9	3.1%
Legal Guardian	7	2.4%
Detention	3	1.0%
Inpatient psychiatric unit	2	0.7%
Pre-adoptive placement	1	0.3%
Permanent foster care	1	0.3%
Temporary foster care	1	0.3%

Criminal Involvement

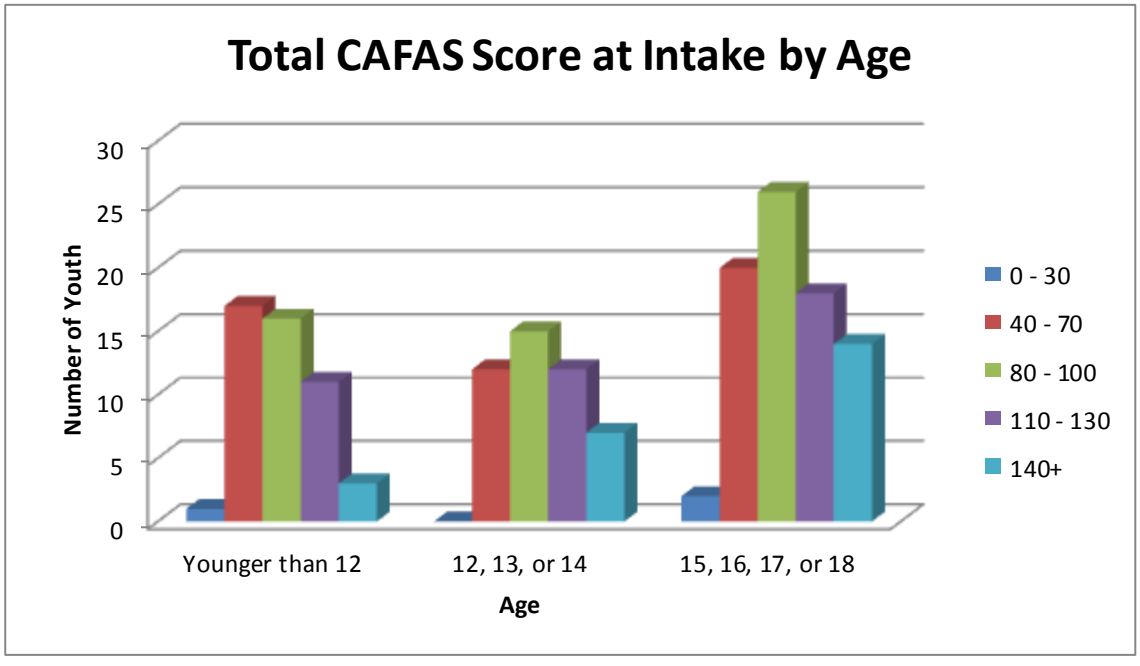
6.2% (18) of youth entering the Wraparound program had been involved in criminal activity during the 30 days prior to intake. Over half of these (10) had committed a probation violation.

Functioning

Child functioning was measured using the CAFAS, a tool comprised of eight subscales assessing the youth's behavior and two assessing the caregiver and the youth's environment. Only the youth subscales were used in this evaluation. The rater (a clinician trained to be a reliable CAFAS rater), identifies behaviors present during a reference period, generally the last 90 days. Items are grouped into four levels of severity: severe (severe disruption or incapacitation); moderate (persistent disruption or major occasional disruption of functioning); mild (significant problems or distress); and minimal or no impairment (no disruption of functioning). The scores associated with the levels are 30, 20, 10, and 0, with higher scores indicating more pronounced impairment. Scores are generated for each of the eight scales and a total CAFAS score is generated by summing the eight scales.[7]

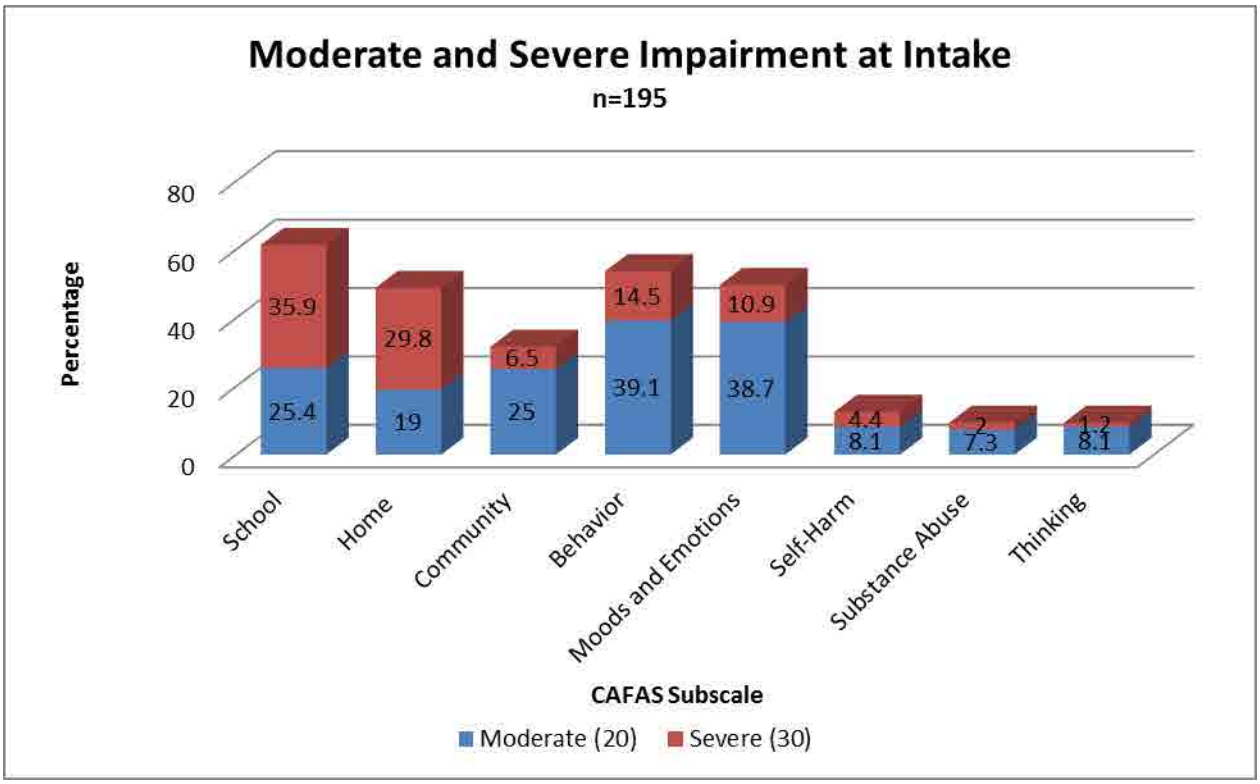
The total score is indicative of the youth's overall functional impairment.

Total CAFAS Score at Intake N=195		
	Frequency	**Percentage**
0 - 30	6	2.4%
40 – 70	49	19.8%
80 – 100	62	25.0%
110 – 130	50	20.2%
140+	28	14.4%



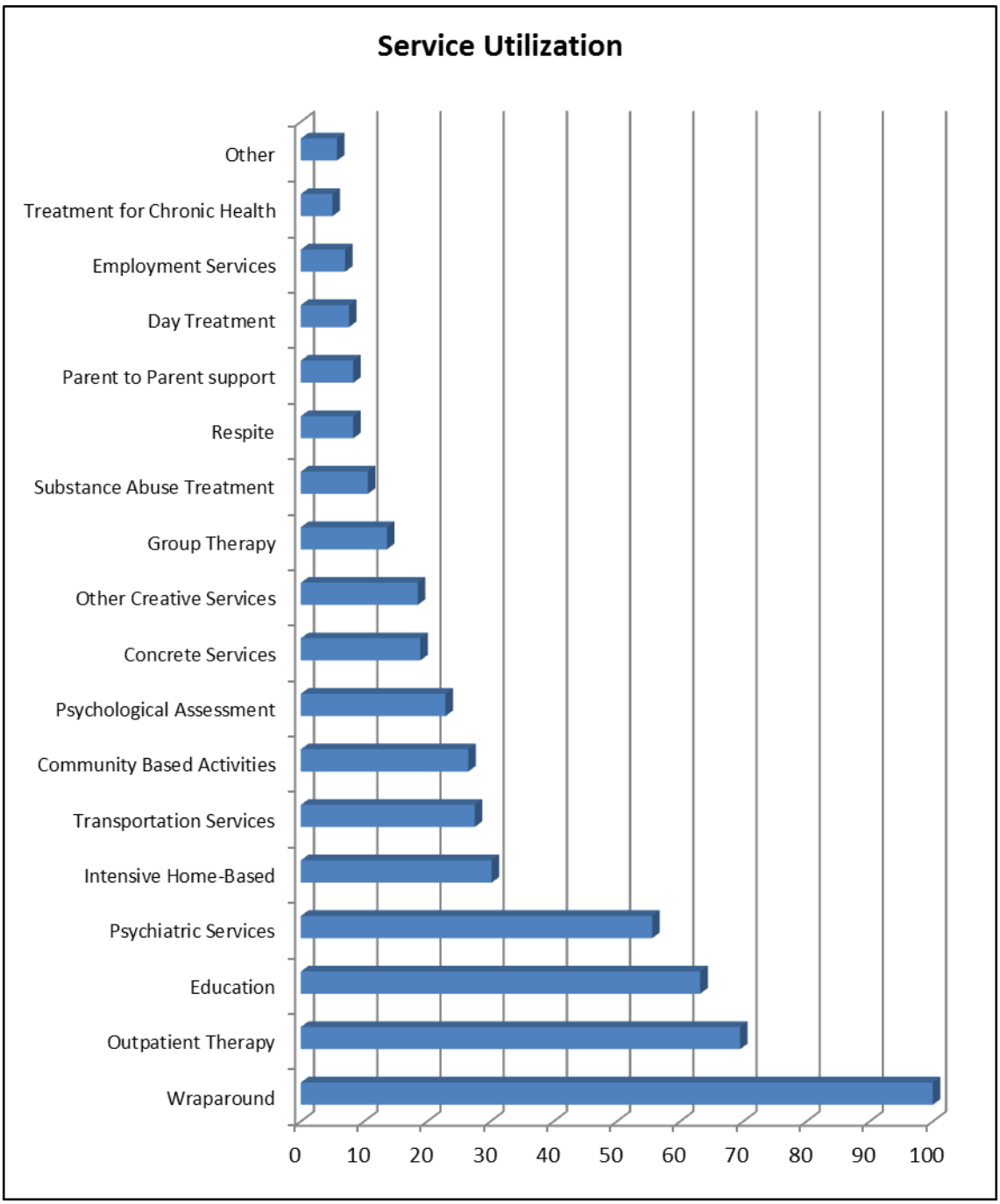
[7] Hodges, K., Doucette-Gates, A., & Liao, Q. (1999). The relationship between the Child and Adolescent Functional Assessment Scale (CAFAS) and indicators of functioning. Journal of Child and Family Studies, 8, 109–122.

The distribution of Severe and Moderate scores on subscales at intake is depicted below. Severe scores are most prevalent in the School/Work subscale, followed by the Home subscale. Such scores are typical of SED children, and such severe behaviors are often one of the main factors preceding entry into Wraparound services.

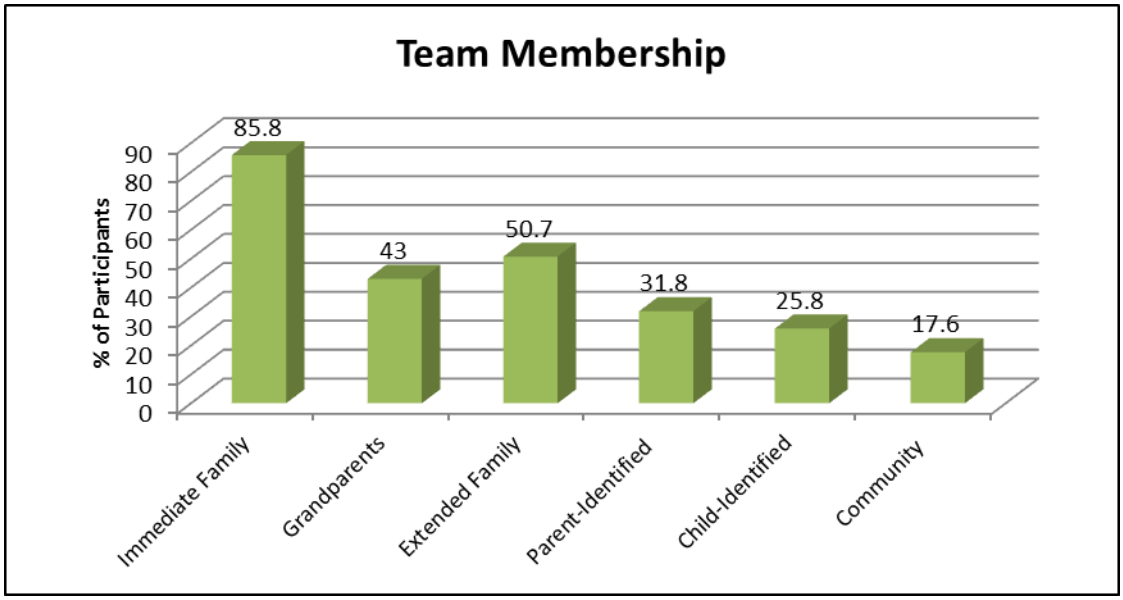


Services Received and Team Membership

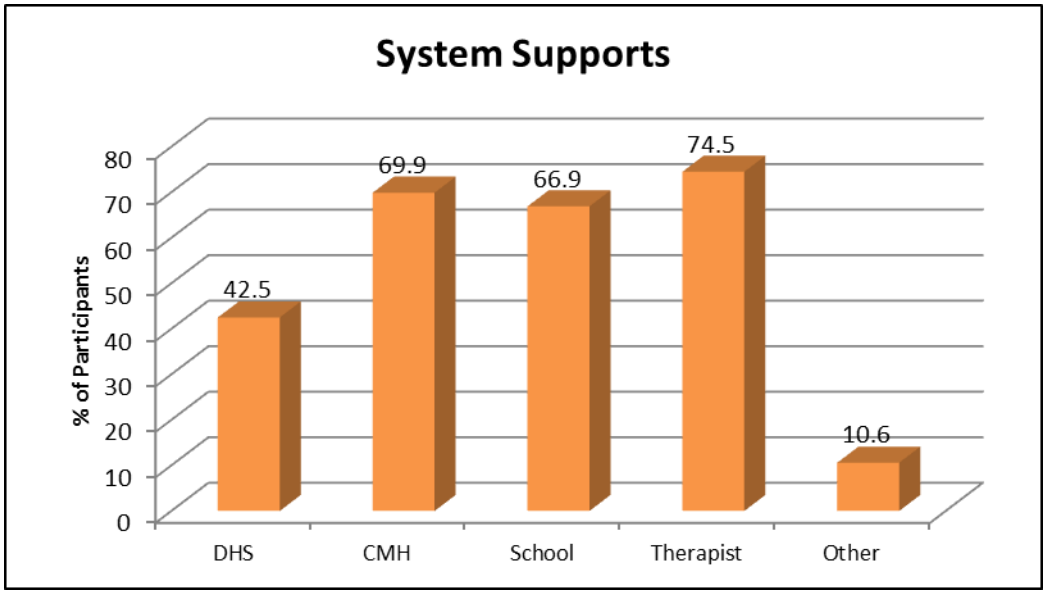
Following the principles of the Wraparound process, families are referred to a number of community-based services in order to meet the needs of the families involved. Outpatient therapy was the most common service utilized, with nearly 70% of youth receiving services. Service categories are not exclusive, as a consumer could potentially receive Outpatient Therapy, Education Services, Psychiatric Services, and Respite at the same time.



Team membership is another essential component to the Wraparound process. Child and Family teams help develop an individualized plan that involves appropriate community resources, services, and supports. Teams should be made of individuals that know the youth the best. In Wayne County, family members, both immediate and extended, are most commonly found on the teams. The graph below indicates team membership at any time during the process.



Similarly, child-serving system partners also sat on the Child and Family teams when appropriate.



Is the Wraparound process being implemented as intended?

To begin to assess fidelity of Wraparound in Wayne County, a self-report fidelity measure was used. Results indicate that caregivers feel their experience in the process is in agreement with the overall philosophy of Wraparound.

Caregiver Demographics

N=47

Gender of Child/Youth		
	Frequency	**Percentage**
Male	34	72.3%
Female	13	27.7%

Ethnicity of Child/Youth		
	Frequency	**Percentage**
Black/African American	29	61.7%
White/Caucasian	14	29.8%
Hispanic/Latino	1	2.1%
Multi-ethnic	2	4.3%
Not specified	1	2.1%

Age When Child/Youth Began Wraparound		
	Frequency	**Percentage**
Younger than 12	10	21.3%
15,16, or 17	14	29.8%
12, 13, or 14	23	48.9%

Time (to date) in Wraparound		
	Frequency	**Percentage**
6 months – 1 year	17	36.2%
0 – 6 months	22	46.8%
1 – 2 years	8	17.0%

Youth Demographics

N=70

Gender of Child/Youth		
	Frequency	**Percentage**
Male	49	70%
Female	21	30%

Ethnicity of Child/Youth		
	Frequency	**Percentage**
Black/African American	38	54.3%
White/Caucasian	21	30%
Hispanic/Latino	3	4.3%
Multi-ethnic	4	5.7%
Other/Not noted	2	2.9%

Age When Child/Youth Began Wraparound		
	Frequency	**Percentage**
Younger than 12	17	24.3%
12, 13, or 14	18	25.7%
15,16, or 17	33	47.1%
18 or older	2	2.9%

Time (to date) in Wraparound		
	Frequency	Percentage
0 – 6 months	31	44.3%
6 months – 1 year	29	41.4%
1 – 2 years	8	11.4%
Not answered	2	2.9%

Fidelity to the 10 Principles of Wraparound[8]

1. Family voice and choice. Family and youth/child perspectives are intentionally elicited and prioritized during all phases of the wraparound process. Planning is grounded in family members' perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences.

Caregiver Responses				
Survey Item	**Yes**	**More Yes than No**	**More No than Yes**	**No**
People on my team who are friends or family members have enough say in making the Wraparound plan.	63.6% (28)	29.5% (13)	2.3% (1)	4.5% (2)
My ideas and opinions are welcomed and included in the program.	89.1% (41)	10.9% (5)	0% (0)	0% (0)
Team decisions are based on what we wanted to do and what we were able to do.	78.3% (36)	21.7% (10)	0% (0)	0% (0)

Youth Responses				
Survey Item	**A great deal**	**Somewhat**	**Slightly**	**Not at all**
How often were you included in team meetings?	72.9% (51)	24.3% (17)	0% (0)	0% (0)
How often were you included in decisions?	74.3% (52)	20.0% (14)	2.9% (2)	0% (0)
How often were you asked about your needs?	80.0% (56)	8.6% (6)	0% (0)	0% (0)
How often were you asked about your family's needs?	71.4% (50)	22.9 (16)	0% (0)	2.9% (1)

2. Team based. The wraparound team consists of individuals agreed upon by the family and committed to them through informal, formal, and community support and service relationships.

Although no items specific to the team-based principle were present on the Fidelity/Satisfaction survey, caregivers indicated the participants on their Child and Family Team. Immediate family members compromised the majority of team membership.

Caregiver Responses: Team Membership		
	Frequency	**Percentage**
Birth Parent	32	68.1%
Grandparent	19	40.4%
Sibling	15	31.9%

[8] Definitions from: Bruns, E.J., Walker, J.S., Adams, J., Miles, P., Osher, T.W., Rast, J., VanDenBerg, J.D. & National Wraparound Initiative Advisory Group (2004). *Ten principles of the wraparound process.* Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University.

Other Teacher Therapist Scout Master Neighbor Not specified	10 3 2 1 1 3	21.3%
Adult Friend	7	14.9%
Adopted Parent	6	12.8%
Aunt or Uncle	9	19.8%
Cousin	5	10.6%
Friend	5	10.6%
Other Relative	5	10.6%
Step-Parent	5	10.6%
Live in Partner of Parent	4	8.5%

3. Natural supports. The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The wraparound plan reflects activities and interventions that draw on sources of natural support.

Caregiver Responses				
Survey Item	**Yes**	**More Yes than No**	**More No than Yes**	**No**
People on my team who are friends or family members have enough say in making the Wraparound plan.	63.6% (28)	29.5% (13)	2.3% (1)	4.5% (2)
The support of family, friends, and community is a big part of the safety support plan.	70.2% (33)	27.7% (13)	2.1% (1)	0% (0)
My team finds ways to increase support from friends and family.	62.2% (28)	37.8% (17)	0% (0)	0% (0)

4. Collaboration. Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound plan. The plan reflects a blending of team members' perspectives, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the team's goals.

Caregiver Responses				
Survey Item	**Yes**	**More Yes than No**	**More No than Yes**	**No**
When my team has a good idea for a support or service for my child, we can find what we need or figure out how to make it happen.	73.9% (34)	23.9% (11)	2.2% (1)	0% (0)
My team has been able to get the community	71.7% (33)	26.1% (12)	2.2% (1)	0% (0)

support and services that are in the Wrap plan.				
My team assigns specific jobs to all team members at the end of each meeting.	60.0% (27)	35.6% (16)	2.2% (1)	2.2% (1)
My team reviews each team member's follow-through on their jobs at the next meeting	63.6% (28)	29.5% (13)	2.3% (1)	4.5% (2)
Members of the team make sure everyone does their part of the Wrap plan.	65.2% (30)	32.6% (15)	2.2% (1)	0% (0)
My team knows what the Community Team does in the Wrap process.	60.0% (27)	35.6% (16)	4.4% (2)	0% (0)

5. Community-based. The wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote child and family integration into home and community life.

Caregiver Responses				
Survey Item	**Yes**	**More Yes than No**	**More No than Yes**	**No**
The Wraparound plan does a good job making use of community resources.	75.0% (33)	25.0% (11)	0% (0)	0% (0)
We have been given what we need to know about community resources.	82.9% (34)	17.1% (7)	0% (0)	0% (0)
After Wraparound has finished, my child and family will know how to find community resources.	64.4% (29)	35.6% (16)	0% (0)	0% (0)

6. Culturally competent. The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/youth and family, and their community.

Caregiver Responses				
Survey Item	**Yes**	**More Yes than No**	**More No than Yes**	**No**
My Wrap team always uses words that my family can understand.	78.3% (36)	21.7% (10)	0% (0)	0% (0)
My home visitor treated me and my family with respect.	82.6% (38)	15.2% (7)	0% (0)	2.2% (1)
All members of my child/family team were sensitive to my values, identify, and beliefs.	75.0% (30)	22.5% (9)	2.5% (1)	0% (0)

7. Individualized. To achieve the goals laid out in the wraparound plan, the team develops and implements a customized set of strategies, supports, and services.

Caregiver Responses				
Survey Item	**Yes**	**More Yes than No**	**More No than Yes**	**No**
Team decisions are based on what we wanted to do and what we were able to do.	78.3% (36)	21.7% (10)	0% (0)	0% (0)
My Wrap team encourages my child and family to become involved in activities we enjoy.	71.1% (32)	26.7% (12)	0% (0)	2.2% (1)

8. Strengths based. The wraparound process and the wraparound plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.

Caregiver Responses				
Survey Item	**Yes**	**More Yes than No**	**More No than Yes**	**No**
The supports and services in the Wrap plan use the strengths and abilities of my child and family.	69.6% (32)	28.3% (13)	2.2% (1)	0% (0)

9. Persistence. Despite challenges, the team persists in working toward the goals included in the wraparound plan until the team reaches agreement that a formal wraparound process is no longer required.

Caregiver Responses				
Survey Item	**Yes**	**More Yes than No**	**More No than Yes**	**No**
The Wrap process will go on until the outcomes we want have been met.	73.9% (34)	19.6% (9)	0% (0)	6.5% (3)

10. Outcome based. The team ties the goals and strategies of the wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.

Outcomes drive the Wraparound process. Although caregivers and youth were not asked to specifically acknowledge the use of outcomes in this survey, the presence of individualized outcome tracking forms and regular updates made to Wraparound Plans indicates that this aspect of model fidelity is being conformed to in Wayne County.

Are families satisfied with their experience in Wraparound?

Families were also asked questions about satisfaction on the Caregiver/Fidelity survey. Results suggest that both caregivers and youth were satisfied with the quality of services they received as well as their overall experience in Wraparound. Additionally, caregivers were likely to recommend Wraparound to friends or family in similar difficult situations.

Caregiver Responses				
Survey Item	**Yes**	**More Yes than No**	**More No than Yes**	**No**
The services my family received as a result of the Wraparound process were of good quality.	68.1% (32)	27.0% (8)	2.1% (1)	0% (0)
I would recommend the Wraparound process to a friend in a similar situation as mine.	68.1% (32)	17.1% (8)	2.1% (1)	0% (0)
Overall, I'm glad I participated in the Wraparound process.	70.2% (33)	12.8% (6)	2.1% (1)	0% (0)

Youth Responses				
Survey Item	**A great deal**	**Somewhat**	**Slightly**	**Not at all**
How satisfied were you with the quality of the services and supports that you received in Wraparound?	78.6% (55)	12.9% (9)	0% (0)	0% (0)
How satisfied were you with your overall experience in Wraparound?	81.4% (57)	11.4% (8)	0% (0)	0% (0)

Open-Ended Questions

In order to better understand the experience of families involved with Wraparound, caregivers and youth were asked three open ended questions about what they liked best and least about the process, as well as asked for ideas for improvement.

What did you like best about the Wraparound process?

Caregiver Responses

Caregivers were most likely to indicate that they liked everything about the process, especially the facilitator and child and family team. Wraparound staff members were described as very respectful, professional, compassionate, encouraging, and supportive. Caregivers valued the ability to meet at their own home, where they are comfortable, at consistent times that are convenient for them and their families. Some caregivers also felt the process taught them to be able to work out their own family problems by using family, friends, and other social supports; and the services helped them to better understand the challenges associated with their child's mental illness.

Youth Responses

Overwhelmingly, youth responding to this question cited their particular Wraparound facilitator. Several stated that the facilitator had become like a member of the family. They enjoyed that the facilitator took time to talk with the youth and teach them techniques for keeping their behavior under control. Several also noted that they liked the team aspect of the process. They felt they were listened to by the team, valued the consistency of the meetings, and liked watching their whole family work together. Additionally, youth liked that their facilitator helped them with school, got them involved in activities such as baseball, and put them in touch with concrete goods, such as scholarships and other financial help.

What did you like least about the Wraparound process?

Caregiver Responses

Most caregivers felt there were no negative things to be said about their experience in Wraparound, and two specifically noted that the process far exceeded their expectations. Although several requested more time with their facilitator, including wanting daily visits from him or her, a few reported facing challenges attending meetings and keeping appointments.

Youth Responses

Few youth responded to this question. Those that did mentioned that the part of the process they liked least was sitting in the room, presumably at the meeting, or being on probation. One specifically mentioned disliking the fact that the facilitator went to the youth's school and spoke with teachers and other school staff.

What could be done to make the Wraparound process better?

Caregiver Responses

Among the half of the respondents who completed this question, the majority felt the process was working successfully as it is currently being implemented. Several suggested that they might benefit from more frequent meetings with the facilitator or more frequent therapy sessions for their child. Transportation was mentioned as a significant problem; caregivers felt they could benefit from facilitators driving their youth around to receive services or participate in other activities. Other recommendations included a 24 hour call number, increases to the city budget to provide more programs, and group activities.

Youth Responses

Many youth respondents indicated that they were satisfied with the process as it is and would not like to change anything about it. Two suggested that Wraparound could be improved if the facilitator would do more activities with the youth, such as take them to movies or help them get things.

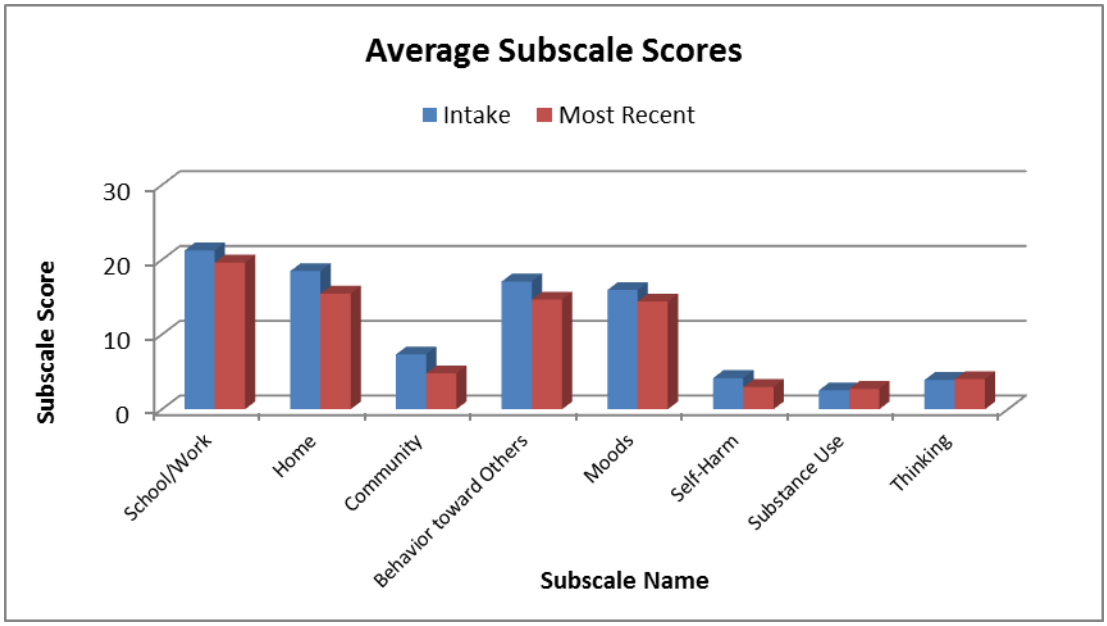
Does involvement in Wraparound result in improved functioning for youth?

As described above, Child & Adolescent Functional Assessment Scale (CAFAS) and Preschool & Early Childhood Functional Assessment Scale (PECFAS) data were collected quarterly and used to measure the youth's functioning across critical life domains and to determine functional improvements over time. The CAFAS and PECFAS are completed by trained practitioners based on information from clinical evaluations at three month intervals. The CAFAS, intended for youth age 7-17, covers eight domains: school, home, community, behavior toward others, moods/emotions, self-harmful behavior, substance abuse, and thinking problems.

Change in CAFAS scores can be used to measure an improvement in functioning across these domains. To measure any improvement in the youth receiving Wraparound services in Wayne County, CAFAS data was analyzed for 84 consumers that had received services for at least 6 months, and pre/most-recent CAFAS scores were available. Average length of stay was 10 months.

Outcomes – Intake/Most Recent:

- Average Reduction in Total Score: 12.72 points
- Meaningful/Reliable Improvement (Reduction in Total Score of 20+ points) = 46.6%
- Free of Severe Impairment (Had severe impairments at intake, none at most-recent) = 40.4%
- Free of Pervasive Behavioral Impairment (No severe impairment on key subscales) = 40.9%



All subscale scores showed an overall decrease from intake to most recent, with the exception of the Substance Abuse and Thinking scales, which stayed approximately the same. These findings are

consistent with previous CAFAS research which has shown that youth with high scores on these subscales are more impaired, and clinical improvement is more difficult to attain.[9]

Safety Indicators- Intake/Most Recent:
Improvement was also seen among those who reported having engaged in unsafe behaviors prior to Wraparound:

- 87.5% reduced the number of dangerous or reckless actions they engaged in
- 90% reduced the number of times they physically hurt themselves on purpose
- 71.4% reduced the times they physically hurt others on purpose

Out of Home Placement
Reductions in out-of-home placements can also be estimated by examining the cohort of 83 participants that had been receiving services for at least 6 months. Among these youth in Wraparound, 6.7% experienced a reduction in the restrictiveness of their placement, moving from an out-of-home setting into either a natal or permanent adoptive home.

[9] Hodges, K., Kue, Y., Wotring, J. (2004). Use of the CAFAS to Evaluate Outcome for Youths with Severe Emotional Disturbance Served by Public Mental Health. *Journal of Child and Family Studies*, Vol. 13:3, pp. 325–339.

Summary and Recommendations

The process of Wraparound poses unique challenges for evaluation. Unlike other practice models that suggest outcomes based on fidelity to model principles, Wraparound is an individualized process that develops a plan of services specifically tailored to the family so success in the program can mean different things to different families. Additionally, Wraparound serves children and families that are involved in multiple systems which each have individual outcome indicators. Future Wraparound evaluations will consider these factors and determine a more tailored approach to determining whether the program had a positive outcome.

Recommendations

1. *Consider the role of community support in the Wraparound process.* Wraparound works best when families develop relationships with other community members and partners. In fact, in an evaluation of the King County Blended Funded Project in King County, WA, found the program's ability to develop community relationships and supports for families was among the most important contributing factors to program success.[10]

   The Community Supports for Wraparound Inventory (CSWI) is one tool that could be useful at assessing current system context and track change and improvements over time. Developed by the National Wraparound Initiative, the instrument presents forty community or system variables that are conducive to strong Wraparound implementation and asks participants to self-report the status of their community. Six themes are covered: Community Partnership, Collaborative Action, Fiscal Policies and Sustainability, Access to Supports and Services, Human Resource Development and Support, and Accountability.

2. *Increase the utilization of Parent Support Partners (PSPs).* PSPs are a great example of community supports available in Wayne County, and PSPs have the ability to guide families through the Wraparound process as well as help them sustain in the community.

3. *Develop a comprehensive way to measure family outcomes.* Since Wraparound is an individualized process, goal and outcomes are unique to each participating family. Many individual-based outcomes are already being captured by current evaluations, such as remaining in the community or academic success, yet others might continue to be missed. These might include outcomes related to improvements in family stability, additional services utilized by other family remembers as a result of the Wraparound process, or unique achievements of

[10] Jones, B. (2008). Creating community-driven wraparound. In E. J. Bruns & J. S. Walker (Eds.), *The Resource Guide to Wraparound.* Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children's Mental Health

goals set by the family. Future evaluations should include measures to capture the diversity of outcomes.

4. *Develop a tool to measure fidelity to the Wraparound model.* Although Wraparound is an individualized process, fidelity to key principles is necessary to guarantee universal delivery of services across Wayne County. As described above, the current evaluation utilizes self-report fidelity measures. This could be combined with observations, chart audits, and other activities.

Chapter 7: Kids-Talk

The Kids – Talk program handles cases of alleged sexual abuse, severe physical abuse, and witnessing of violence involving children 17 years old and under. The program provides a child-friendly environment and employs specially trained child forensic interviewers to assist in abuse investigations.

Kids-Talk has three major components- forensic interviews, investigative coordination, and counseling services. Forensic interviews are conducted pursuant to State of Michigan protocol to minimize the effects of trauma on child participants, alleviating children from having to repeat the events to multiple parties. Kids-Talk also coordinates the investigative efforts of all agencies involved in the law enforcement; Wayne County Department of Human Services, Child and Family Services; the Attorney General's Office Family Court; the Wayne County Prosecutor's Office; and the medical and mental health communities. Additionally, Kids-Talk provides counseling services to the abused victims and offers referrals for the following services: medical, financial, legal, and housing. Informational folders are given to parents or guardians and contents are reviewed and explained by a Kids-Talk staff member.

An evaluation of Kids-Talk program in FY2010-2011 was completed by staff at The Guidance Center. Results from that report are presented in this chapter, modified slightly to fit the format of this document.

Consumers Served

There were a total of 913 Kids-TALK interviews conducted and advocate logs completed for the 2010-2011 fiscal year. Out of the 913 youth, 892 were unduplicated. There were a total of 669 females, (74.0%) and 238 males, (26.2%) that had gone through the interview process. Out of the 913 interviews conducted, 672 (74.0%) were between the ages of zero- 12 while 238, (26.2%) were between the ages of 13-17.

One hundred and sixteen individuals received therapy: 17 of those individuals were adult survivors of child sexual abuse while the other 99 included children. There were 220 case management contacts that were completed within two weeks after the Kids-Talk interview and 66 successful follow-up contacts made to families at three months after the interview.

Data Collection

The Kids – Talk program works to incorporate all various agencies and resources involved with and available to children victimized by sexual abuse, physical abuse, and witnesses of violence. The programs also works to provide parents or guardians with any and all available information to help them keep their child safe and are able to receive the resources that are needed. The Kids – Talk program administers several surveys/questionnaire to those involved in a case which includes: children, parents or guardians, and community partners. A demographic questionnaire is given to the parent or guardian of a child who has just entered the program. The information attained in this questionnaire is broken down into four parts which include: alleged victim(s) and parent(s)/guardian(s); alleged perpetrator(s); community partner(s); and information and referrals.

Kids-Talk Survey	
Instrument	**Number of Responses**
Parent/Caregiver Survey	486
Youth/Consumer Survey	10
Parents Therapeutic Survey	6
Community Partner Survey	37

Parent/Caregiver Satisfaction Survey

At the end of the interview the parent(s) or guardian(s) are given a satisfaction survey which contains 14 questions. A location is checked where a services were received. Locations available are Hutzel Hospital, The Guidance Center, Grosse Point, and Livonia.

Youth/Consumer Survey

A Consumer's Feedback questionnaire is administered to the child to indicate level of satisfaction of therapeutic services. The survey consists of eight total statements and questions which indicated the consumer's level of agreeability toward therapeutic services received.

Parent/Caregiver Therapeutic Survey

A parents'/caregivers' feedback survey about therapeutic services is given to parents or guardians to indicate the benefits that they and their child(ren) have received from therapeutic services. The survey consists of 10 total items which include statements, questions, and comments.

Parent/Caregiver Follow-Up Surveys

If the parent/caregiver grants permission for a follow-up interview, a follow-up survey is administered to the parent/caregiver within two weeks of the child's forensic interview. This follow-up report consists of seven sections, which include: demographic, medical, legal, counseling services, crime victim's compensation, miscellaneous services, and comments. A three month family follow-up interview is a phone interview conducted to assess how the client and clients' family is coping with their specific situation. The Kid's-Talk advocate attempts to contact the family three times. During the phone attempts it is noted if the phone was disconnected, wrong number, parent refused the interview, or if contact was made along with the date. A script is read by the Kid's Talk advocate to ensure consistent interview process, guarantee confidentiality, and allow access to additional support. Interview questions evaluate the effectiveness of legal information, the behavioral status of the child, and suggestions for things Kids-Talk could have done to ease the family through the process. If necessary, additional service recommendations are made.

Community Partner Surveys

The Kids-Talk community partner's survey is mailed or emailed to all partnering community organizations, including law enforcement, prosecutor's office, DHS, and medical offices. The Community Partners Survey consists of 11 statements and questions.

Findings

Legal Advice

At the beginning of the process, the family advocate is responsible for giving information to the victim and parent/caregivers on what to expect in the forthcoming legal process, as well as referrals to specific organizations to assist the client and families during these processes. Advocates report that a packet of information regarding the legal process was given to 95.0% of families involved in the program, with 7.6% of them also receiving referrals for specific legal services. Additionally, at the 2-week follow-up, advocates reported referring an additional 0.9% to legal services. Parent/caregivers report that legal information was given to them by the advocate 99.2%, but only 39% report utilizing legal services. Advocates conducting the 3-month follow-up reported that 88.9% of families found the legal information they received helpful.

Counseling/Trauma

The advocate is also responsible for providing information to the family on counseling services for both the child and non-offending parent, as well as information on what behaviors the child may display as a result of trauma. Additionally, the advocate provides referrals to specific organizations for counseling services in cases where appropriate. For the 2010-11 year Kids-Talk advocates reported giving information on children's behaviors as a result of trauma to 95.2% of parents, as well as referrals for counseling services for the child and non-offending parent (84.9% and 85.4%, respectively). Respondents to the parent/caregiver surveys reported that 98.6% received information on behaviors to expect as a result of trauma, with 99.2% receiving information on counseling services as well. In the 2-week follow-up, advocates reported that 33.8% of families utilized referrals for counseling, with an additional 40.6% of families receiving referrals at the time of follow-up. In the 3-month follow-up, 90.3% of families found the information on behaviors to expect helpful and only 47.7% reported that they observed said changes in behavior.

Medical

A medical component to the Kids-Talk program, which helps to ensure that children receive a medical exam following sexual abuse and any additional medical services they may require. Advocates report that 42.7% of the children they saw were given a medical exam prior to Kids-Talk, with an additional 20.1% and 19.2% referred for a medical exam or additional medical service, respectively. At the time of the 2-week follow-up, advocates reported that 59.5% of families utilized the medical referrals they received and referred an additional 0.9% of families for medical services.

Crime Victim Compensation

Another component analyzed in the surveys is the dissemination and use of information on crime victim compensation. Advocates reported to giving out information on crime victim compensation to 94.9% of the families and referring 8.5% of them to specific organizations for assistance in receiving proper compensation. At the 2-week follow-up advocates found that 0.9% of families utilized the referrals and they referred an additional 3.2% of families.

General Referrals

There are many other services that families in the Kids-Talk program need and they are combined into the categories of community resource and other referrals. Advocates reported giving 93.8% of families referrals for community resources, with another 21.7% receiving referrals for other services. These statistics are upheld by the parent/caregiver surveys where they report that 99.4% of families receive referrals to community resources. Furthermore, at the time of the 2-week follow-up, advocates reported giving 24.1% of families community resource referrals and 3% other referrals. It was reported that 30.3% of families had utilized these referrals at the time of the 3-month follow-up.

Referrals were also given for a number of services not listed above. These services included housing assistance, financial assistance and parenting skills classes. Advocates provided referrals for parenting skills, housing assistance, and financial assistance to 2.6%, 1.7% and 1.5% of families, respectively. Additionally, parents/caregivers reported 98.9% received information from Kids-Talk about what to expect from DHS.

Safety Plan/Personal Protection Order

An additional component of the Kids-Talk program is to help families create a safety plan and get a personal protection order against the offending party. Advocates reported that a safety plan was created for 68.4% of families and an additional 5.3% were referred for a personal protection order. Furthermore, 99% of respondents to the parent/caregiver surveys stated that they were assisted in creating a safety plan. At the time of the 2-week follow-up advocates reported that 1.8% of families had filed for a personal protection order.

Kids-Talk Therapeutic Services

A portion of the families involved in the Kids-Talk program also utilized the therapeutic services offered by Kids-Talk. Parents and youth who participated in these services responded to a survey to determine the effectiveness of these services. It is important to note that only 6 parent surveys and 10 children surveys were recorded, so the results of this section have limited statistical significance. However, all 6 of the respondents to the parent surveys reported positive answers regarding Kids-Talk therapeutic services on each question. Of the 10 children surveyed, all felt better as a result of therapy, that they could identify a safe person, that abuse was not their fault and that the program overall helped them. Furthermore, 80% reported they understood how most people respond to abuse and 90% reported they knew how to get help.

Community Partner Education

The community partner surveys also assessed components of community partners' knowledge of the services Kids-Talk provides. Partners were asked if they knew Kids-Talk offered free therapy for children who've experienced abuse, a workspace for community partners at their Ferry St. location in Detroit and whether they understood common responses that children who experience abuse may exhibit. Of those surveyed, 66.7% knew Kids-Talk offered free therapy for children and only 37% knew they provided a workspace for community partners at the Ferry St. location. Furthermore, only 72.4% reported understanding the common responses children may exhibit due to abuse. These statistics indicate that

Kids-Talk needs to improve communication with community partners over what Kids-Talk can provide victims and community partners alike.

Family Satisfaction

Family satisfaction was measured through the responses to four questions on the parent/caregiver survey. The questions asked were in regards to the courteousness of the Kids-Talk staff, ability of families to ask questions about the process, staff concern for the child and the supportiveness of the staff. Parent/Caregivers reported extremely high satisfaction with the Kids-Talk Staff.

Parent/Caregiver Satisfaction with Staff	
Measure	**Percent with favorable response**
Treated courteously	99.1%
Opportunity to ask questions	99.6%
Staff concern for child	99.6%
Supportiveness of staff	99.4%

Community Partner Satisfaction

Satisfaction with the program was also measured through community partner satisfaction surveys. Community partners refer to members of other organizations involved in the process of a case of sexual abuse, which includes, law enforcement, the Prosecutor's office, DHS and medical personnel. Overall Kids-Talk received very favorable reviews from its community partners. In regards to the interview, 100% of respondents reported that Kids-Talk was timely in setting up an interview, that the interview process went smoothly and that the interviewer remained unbiased, with 92.3% reporting that it was easy to set up an interview. Additionally, 89.6% would refer cases to Kids-Talk without a mandate to do so, 96.5% would recommend Kids-Talk to other professionals, 89.3% that Kids-Talk makes their job easier and 96.3% found the staff helpful. Community partners also reported that Kids-Talk displayed a timely response to referrals 100% of the time and 96.3% that the presence of the family advocate was helpful for families. Furthermore, the only questions where partners reported lower than 89% satisfaction were the pre and post multidisciplinary team meetings, 76.2% and 76.0% respectively.

Parent/Caregiver Suggestions

Open ended responses of parents/caregivers were included in regards to the most helpful part of the Kids-Talk program. Of the responses, some of the most popular components of the program were the information given about the process to follow the abuse, the support of the staff and friendly atmosphere they create, and the concern the staff showcases towards the children. Another big component mentioned was the ability of the staff to listen to the concerns of the parents and understand what they were going through. As for places to improve the program, parent/caregivers mentioned better informing parents of the process at Kids-Talk before they take part in it. Improvement in this area would help counteract the feelings of parents that they would like to be present during child interviews, which was one of the areas mentioned for improvement, because they would be aware before the process began that they are not allowed to be present during the interview for legal purposes. Another area mentioned was for Kids-Talk to provide snacks and light refreshments for

youth/parents while they wait, which could aid in making Kids-Talk a more comfortable environment for everyone.

Community Partner Suggestions

Amongst open responses from community partners, the interview process and the child friendly environment were mentioned as the strongest components of the program. They indicated these two areas based on the interviewers being well-trained, only one interview having to be done for the entire process and the ability of the interviewers to make the children feel comfortable. As for places to improve the program, community partners cited better communication amongst community partners and Kids-Talk.

Conclusion

The response of families and community partners involved with Kids-Talk indicate that the program is highly effective in addressing the problems families encounter in the aftermath of sexual abuse. Parent/caregiver satisfaction surveys revealed that greater than 99% of respondents were satisfied with the way the Kids-Talk staff treated them as they were guided through the process. Additionally, high percentages of parents reported receiving information about what to expect over the course of the investigation of sexual abuse and resources that are available to them to help their child and themselves recover from what has taken place in their lives. Parents and advocates reported that information about the legal process, trauma, and counseling were given to them over 94% of the time, with parents reporting percentages greater than 98%. Furthermore, referrals to specific organizations were given to families when requested or deemed necessary for legal, counseling and other community resources. Of the referrals given, families reported using the referrals at a rate below 40% with the only exception being referrals for medical services (59.5%). The majority of families found the information they received helpful, but in most cases did not utilize the referrals that they were given for services.

Another component of Kids-Talk is the therapeutic services that they offer, which were utilized by participants in the program. Of those who participated in these services, only a small number of parents and youths responded to the surveys, but those who did indicated that the services were highly effective in helping victims and their families overcome their recent trauma. The majority of complaints from families were in regards to things Kids-Talk cannot change, such as allowing the parent to be present during the child interview. This indicates that the staff could make the process even clearer to the parents and explain to them in greater detail the legal reasons why they cannot be present during this portion of the process. Also, a number of respondents felt intimidated by the process due to a lack of knowledge about what was going to happen at Kids-Talk. This could be alleviated by making more information available to parents before they get to Kids-Talk about what will happen there, so that they will feel less intimidated as the process begins. Another aspect that could help to alleviate some of the stress is by making small snacks available for parents and children as they wait at Kids-Talk. All this being said the vast majority of responses from parents were positive and they feel that Kids-Talk is providing a helpful and well organized service.

Moreover, community partners (law enforcement, the Prosecutor's office, DHS, medical personnel) reported that the Kids-Talk program is performing at a high level and is an asset to them. However there was an indication that community partners would like better communication between Kids-Talk and themselves in order to improve the program. This is also supported by the low percentages of community partners who knew about the therapeutic services Kids-Talk provides free of charge and the availability of a workstation for them at the Ferry St. location. Improving communication between Kids-Talk and community partners about what specifically Kids-Talk can do will help to improve their working relationship and the ability of both parties to assist families involved in the process. However, community partners report that the interview service Kids-Talk provides is one of the strongest points of the program and helps to alleviate the pressure on victims, who otherwise would have to tell their stories numerous times.