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ABSTRACT

This report is a case study on the process of developing interagency collaboration on behalf of emotionally handicapped children and their families. Based on a process evaluation conducted for the Multnomah (Portland, Oregon) Board of County Commissioners, the case study examines a therapeutic case advocacy project which sought to promote greater coordination among the county's school mental health program and five community mental health centers. The case study evaluates how the project organized, publicized, and established itself during its first year. The report discusses: project background (source of funding, project rationale, selection of participating organizations, and initial goals and assumptions); work group formation; planning and design for interagency collaboration; and service teams for project implementation (team processes, role clarification, accountability, and characteristics of referrals for services). Recommendations are offered for consideration in designing similar projects. An appendix contains a project description and administrative forms. (JDD)

THE MULTNOMAH COUNTY CAPS PROJECT

AN EFFORT TO COORDINATE SERVICE DELIVERY FOR CHILDREN AND YOUTH CONSIDERED SERIOUSLY EMOTIONALLY DISTURBED

A PROCESS EVALUATION

Therapeutic Case Advocacy Project

Research and Training Center
to Improve Services for
Seriously Emotionally Handicapped
Children and Their Families

Regional Research Institute for Human Services
Portland State University
Graduate School of Social Work

June 1987

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INTRODUCTION

In October 1984 a Research and Training Center to Improve Services for Seriously Emotionally Handicapped Children and Their Families was established at the Regional Research Institute (RRI) of Portland State University's Graduate School of Social Work. The Center was funded conjointly by two federal agencies: the National Institute on Disability and Rehabilitation Research (NIDDR) within the U.S. Department of Education and the National Institute of Mental Health (NIMH) within the U.S. Department of Health and Human Services.

At this time the Center houses three projects devoted to improving services for emotionally handicapped children and their families and a Resource Service that issues a quarterly newsletter entitled Focal Point. The three projects are named Families as Allies, Youth in Transition, and Therapeutic Case Advocacy. Readers desiring further information about the Center and its projects may wish to refer to the last page of this report for details.

The Therapeutic Case Advocacy Project is developing a multi-level model of interagency collaboration that combines case advocacy, care management, and interpersonal intervention skills in order to establish and maintain a system of care surrounding these children and their families. We think of the model as being multi-level in nature because it addresses the family and child, the organization employing the Therapeutic Case Advocate, and the interagency network that makes possible the coordinated provision of services that help make up the system of care.

The details of the model, including the skills that have to be acquired and the kind of organizational support that must be developed to sustain it, are being assembled in a Therapeutic Case Advocacy Training Manual and Worker's Training Guide that will be distributed nationally along with a videotape illustrating the model's application and an extensively annotated bibliography

on child advocacy.

This report is a product of interagency collaboration that we have decided to publish separately as a case study in the process of developing interagency collaboration on behalf of emotionally handicapped children and their families. It is based on a process evaluation we conducted for the Multnomah (Portland, Oregon) Board of County Commissioners. The Board had set aside special funds for a demonstration project (the CAPS Project) to promote greater coordination among the County's School Mental Health Program and the five Community Mental Health Centers serving Multnomah County.

Through Davene Cohen, Program Developer for children's mental health services, we were asked to conduct an evaluation of the process through which the project organized, publicized, and established itself during its first year, fiscal year 1986. This provided us with an unusual opportunity to observe firsthand the trials and tribulations of creating a multi-agency pilot project.

We are grateful particularly to Dave Pump, Supervisor of the Multnomah County School Mental Health Program, for the access he provided us to all of the planning meetings among the participating agencies.

I. Project Background

A. Source of Funding and Project Rationale

The CAPS Project was influenced by the work of several local committees, individuals, and agencies over the two years prior to the project's actual inception.

In 1984, the Multnomah County Children's Mentally or Emotionally Disturbed (MED) Work Group (consisting of representatives of the Children's Services Division, the public schools, the United Way, a citizen advocacy group and others) recommended that a multi-system pilot project was needed to demonstrate the feasibility of coordinating the delivery of services to seriously emotionally handicapped youth and children.

The Public Agency Forum (an ad hoc committee of direct service providers of mental health services to children such as the state hospital, the Children's Services Division, the county mental health staff, the juvenile court and psychiatrists) identified the need for integrating services delivered to SED youth in transition (i.e., youth "aging" out of the youth mental health system into the adult system).

The Multnomah Target Child Committee, an outgrowth of an informal manager's network to solve jurisdictional issues, suggested that seriously emotionally disturbed youth with multiple problems or involved with multiple agencies often fall through the cracks in the absence of service coordination.

The Multnomah Board of County Commissioners' Youth Resolution (proposed by a diversion services task force) identified the need for service coordination to enhance service delivery for youth and children involved with multiple agencies.

The efforts of these local committees had a common focus: the need to align school mental health services, publicly funded community mental health services for children and youth, and privately-operated child and youth service agencies in the community such that: (1) programs would not compete over the same

children; (2) the respective roles of providers of treatment, services, and resources were better understood, utilized and supported; and (3) providers would recognize their common interests and develop methods of interagency collaboration to comprehensively deliver services to emotionally handicapped youth and children.

Even though a constituency of agencies had developed, financial support for implementing a program was still lacking. County administered programs and agencies supported with county funds were asked what they would do if they could add 5 percent to their budgets. Responses focused on two primary areas: (1) mental health outpatient services; and (2) school mental health services. Eventually this dual focus was collapsed into one general concept with one funding base, and the Multnomah County Board of Commissioners responded to this documented and perceived need for coordinated services through a commitment of additional funds.

The concept that was funded was one of service coordination for seriously emotionally disturbed children and youth who are involved with two or more service agencies, or in need of more than one type of service (including mental health) and where an integrated service plan involving the County's School Mental Health Program, the children's mental health service contract agencies, child welfare agencies, juvenile justice programs, and other services were required.

Multnomah County appropriated $100,000 to develop and implement a service coordination program. The program, operated over FY 85-86, was administered by the Multnomah County School Mental Health Program. (This program provides mental health consultation to regular classroom teachers before children are referred for special education services). The School Mental Health Program negotiated priority service contracts with five providers of children's mental health services and hired two CAPS Coordinators to assemble service teams for

each child and to facilitate the collaborative interaction of their members. Each contract agency was to take 16 CAPS cases during the first year of the project.

B. Selection of Participating Organizations

Multnomah County ordinarily funds child mental health services through community mental health centers (CMHC's) in each of the five geographic areas that together comprise the county. These agencies are:

1. The Center for Community Mental Health (Northeast Portland)
2. Delaunay Mental Health Center (North Portland)
3. The Morrison Center (Southeast Portland)
4. The Morrison Center (East County)
5. Mental Health Services West (West Portland)

The participation of these contract agencies was essential because they would provide CAPS with service-assured slots for child and youth mental health services in a given geographic area. The service-assured slots were needed since many youth and families seeking services fell through the cracks while awaiting mental health treatment. The community mental health centers had waiting lists and there were no administrative criteria specifying who was required to provide mental health services to which seriously emotionally handicapped children and youth. The slots guaranteed that at least CAPS-eligible youth would receive mental health services. Part of the CAPS eligibility criteria required attendance at a publicly funded school, necessitating involvement by the Multnomah County School Mental Health Program. Hence the CAPS staff and contracted mental health agency staff comprised the nucleus of a unique, interagency service team. In addition to CAPS and School Mental Health staff on each child's interagency service team, other agencies represented would be determined by several factors including:

- the needs of the child identified on the CAPS service plan;
- needs identified by the family, workers, or the child; and
- needs identified by other agencies who provided service to a given child.

C. Initial Goals and Assumptions

By design the CAPS Project sought to coordinate mental health and other services delivered to children and youth who were seriously emotionally handicapped in a given community. From a program development perspective, CAPS was a pilot project to enhance the impact of mental health treatment by reducing the number of children falling through the cracks and by aligning school mental health and youth mental health resources with other community-based resources and services. The end result was to be a comprehensive service plan, ongoing coordination of services, and the establishment of a service continuum for children and youth in their respective communities.

The project administrators at the County level were clear about the need for an effort such as CAPS. They published a list of intents of the project in materials announcing the start of CAPS, as follows:

1. To enhance networking efforts by mental health, social service and school representatives for children/families who need mental health treatment services.
2. To bridge gaps in service between out-of-home day treatment programs and community-based outpatient treatment.
3. To weave a web of support for children in transition.
4. To reduce duplication of services.
5. To reduce services working at cross purposes.
6. To improve continuity of care for children and families.
7. To weave a web of support for agency representatives involved in providing care for these difficult children and families.
8. To contribute to the knowledge base of eligible youth unserved by CAPS.

These materials were distributed to all of the child and youth serving agencies in the metropolitan area.

D. Revised Goals and Assumptions

Originally, the CAPS project was intended to help primarily those in transition from residential treatment to the community and those who were at

risk of placement. The project also served those children who were less at risk and those who were part of the existing caseloads of personnel at the community mental health centers when the project began. This blurred the initial focus of the project somewhat by extending the target population beyond those children and youth who were either returning from placements or who were in imminent danger of out-of-home placement. It was not easy to discern if there was an actual shift in the goals and assumptions of the project. The original purposes appeared to remain the same, but the realities of overcoming the initial problems of starting a new project did require an accommodation to the contract agencies' existing caseloads.

The CAPS Coordinators focused on two primary objectives: (1) assembling and facilitating the interorganizational service teams; and (2) recruiting support from agencies who could provide a service or resource essential to mental health treatment of children and adolescents with serious emotional problems. The former proved to be quite difficult initially, but was accomplished more easily as the CAPS Coordinators became comfortable with their coordinating role. The latter proved to be an ongoing responsibility in the sense that it was not possible to predict the range of resources, services, and supports necessary to deliver comprehensive and coordinated mental health treatment for every case. Thus, the shift in focus from the initial goals and assumptions to the realities of program implementation may be understood in terms of the demands faced by the CAPS Coordinators to: (1) assemble the CAPS Service Teams; (2) recruit the participation of and sustain their members; and (3) establish additional supports (both formal and informal). In doing so, the overall goals and intents of the project became of less concern than the daily process of conducting the tasks of the project.

As the project unfolded CAPS personnel recognized the difficulty in assembling and coordinating interagency service teams comprised of individuals

from diverse backgrounds, disciplines, fields of practice, and with different work styles, and personalities. Despite the documented pervasiveness of problems caused by poor coordination between organizations, the available literature on this subject contained surprisingly few guidelines for solving them and even fewer recommendations for designing interorganizational linkages to achieve better coordination. Indeed, one measure of CAPS' achievement in its first year was the degree of interagency involvement and cooperation it was able to foster. Another achievement was the awareness that this was a project that would need to be nurtured if it was to mature and develop properly.

II. The CAPS Work Group

A. Work Group Formation

The project was field developed and because of its complexity required ongoing planning. As a result, the County Program Office for the Mentally or Emotionally Disturbed assembled a planning committee or a CAPS Work Group to further flesh out the CAPS model. The Work Group consisted of:

- representatives from each of the contract agencies;
- the Multnomah School Mental Health Program Supervisor;
- the MED Program Office Program Developer responsible for child and youth programs;
- the CAPS Team Coordinators; and
- staff of the Therapeutic Case Advocacy Project of the Research and Training Center to Improve Services for Seriously Emotionally Handicapped Youth and Their Families.

The work group met regularly to determine how the CAPS concept should be implemented. The staff of the Therapeutic Case Advocacy Project participated in these discussions and subsequently conducted this process evaluation.

The formation of a CAPS planning committee was an essential step to implementing the concept. By including the primary participants (the contract agencies) in planning the implementation of CAPS, they gained ownership of the concept and acquired confidence that CAPS would not be imposed on them.

Establishing a CAPS Work Group was also an acknowledgment that the County's

contracted providers of children's mental health services operated differently. The contracting agencies in their respective geographic areas were designed and structured to meet the service needs and environmental contexts of their constitutents. However, since many seriously emotionally handicapped children and youth were falling through the cracks created by differing intake procedures (in combination with waiting lists), the CAPS project established a unified approach toward intake at each of the contract agencies.

The diversity of the contract agencies made the quest for consensus over programmatic issues a little harder to achieve. This was exacerbated in two ways: (1) the represented agencies had to uphold the integrity of their programs by respecting their own service objectives, operating procedures, service capabilities, and community resources; and (2) convening a group of individuals of diverse backgrounds, disciplines, fields of practice, work styles, and personalities was often very difficult. Consensus and cooperation were built upon mutual service goals and objectives. As the perception that CAPS would not be imposed from the top down (i.e., from the County administration to program staff), cooperation increased.

The CAPS concept in itself was not difficult to market as many agency representatives suggested that "some of us already do what CAPS intends to do." This comment served as a backhanded endorsement of the CAPS concept, but it implied even more. Collaboration or coordination previously took place as a result of a worker's individual initiative as opposed to reflecting any programmatic goal or objective. Because the group had to define the role of the CAPS coordinator, the concepts of collaboration and coordination became more formally articulated. Essentially, coordination of services delivered to these children and youth was perceived by the Work Group as the primary focus of the CAPS Coordinator and the direct provision of service (i.e., mental health treatment) remained the primary responsibility of the contract agencies.

The CAPS Work Group met to develop operational procedures which included defining the target population, establishing eligibility criteria, specifying referral procedures, and creating release of information forms. The CAPS Work Group was a critical element in the implementation of the project. Its work did not end as CAPS became operational. In fact, the Work Group continued to convene to discuss and evaluate the project, its procedures, and its impact.

B. Planning and Design for Interagency Collaboration

A primary responsibility of the CAPS Work Group was to develop the project's operating procedures. Two central issues emerged for consideration: (1) would coordination pose a threat to the autonomy of either the contracted or volunteer agencies involved, such that they might be less likely to participate fully? and (2) how would the ability of the contract agencies to reach consensus or make decisions affect the degree of cooperation, and ultimately the accomplishments of CAPS? Essentially the Work Group had to remain sensitive continually to the varying requirements of each agency in coordinating a child and adolescent mental health service team comprised of multiple agencies. As often as possible the Work Group attempted to reach consensus on standards and procedures; however, this was not always without considerable effort and compromise.

The Work Group's approach to problem solving and decision making was quite valuable to CAPS. They discussed a range of issues and implications surrounding the project's implementation. The School Mental Health Program and contract agency participation served to increase the planning and problem solving resource base of the project. Four primary areas of concern were handled by the CAPS Work Group: (1) definition of the target population; (2) funding; (3) referral and intake; and (4) confidentiality.

1. Definition of the Target Population

In a preliminary draft developed by the administrators of the MED project

office and the School Mental Health Program, the population to be served by CAPS was identified for discussion by the Work Group. The proposed target population was to include:

- children who have experienced multiple out-of-home placements;
- victims of abuse, neglect, parental death, and custody shifts;
- children presenting symptoms of mental disorder who are at risk of removal from school and/or home;
- children whose parents are chronically mentally ill, acutely mentally disabled, substance abusers, or in the correctional system; and
- children exhibiting impaired relationship capacity or bizarre behavior.

In addition, to be eligible for the CAPS Team Project any child from the above categories must:

- have a need for mental health services as documented by a qualified mental health professional;
- attend a publicly funded school and be judged able to benefit from networking services from mental health, social, justice and educational agencies; and
- present one or more of the following characteristics:

  1. be currently placed out-of-home
  2. have returned to the community within the last six months, or
  3. require transition support to sustain intervention gains or maintain current placement.

This working definition was subject to amendment and approval by the CAPS Work Group. One area of dispute arose over the issue of whether or not to include children who were <u>not</u> currently placed out-of-home or returning from such a placement. There were those who believed that prevention of placement was as important as facilitating reintegration into the community following placement. Others felt that including "prevention cases" would take needed service slots away from children with more severe emotional problems. Working on a compromise regarding eligibility criteria was perhaps the most difficult task the Work Group faced.

The final decision was that for the first year of CAPS the target population was defined as originally conceived except that the second part of the definition became primary and the first part secondary. The criteria that

all children must meet was stated first as follows:

- had a documented need for mental health services;
- will benefit from networking services from mental health, social service, juvenile justice, and educational agencies and who were eligible to attend a publicly funded school;
- present one or more of the following characteristics--

  1. are currently placed out-of-home; or
  2. have returned to the community within the past six months; or
  3. require transition support to sustain intervention gains.

Membership within any of the high-risk populations listed was considered secondary, to be considered only if the preceding ones were met.

- Children who have experienced multiple out-of-home placements.
- Victims of abuse, neglect, parental death, and custody shifts.
- Children presenting symptoms of mental disorder, who are at risk of removal from school and/or home.
- Children whose parents are chronically mentally ill, acutely mentally disabled, substance abusers, or in the correctional system.
- Children exhibiting impaired relationship capacity or bizarre behavior.

By accepting this final definition of the target population, the Work Group resolved the prevention/severity dispute by including both, while at the same time emphasizing the documented mental health needs of the child rather than risk factors.

2. Funding Concerns

The contracting agencies were very concerned about reaching the service objective of 16 cases per agency who were to receive CAPS services. This apprehension stemmed from the fact that contract agencies would only have six months to achieve this goal. The MED Program Developer agreed that 8 of the 16 cases could be existing ones in the contract agency's open files. This compromise was politically necessary to deflect attention from the service objective issue so that cooperative planning and field development could continue.

The children normally served by the County's contract agencies are funded through a variety of revenue sources. However, contracting agencies were expected to provide 16 CAPS cases with the CAPS services that were not

reimburseable through other funding sources The contract agencies and the MED Program Office agreed on an arrangement that eliminated the possibility of CAPS providing and funding services that could be paid through other revenues. The Work Group identified what interagency cooperation meant operationally in terms of services in addition to those covered by existing cost reimbursement formulae.

3. Referral and Intake Concerns

The way in which the CAPS Coordinators made referrals to the provider agencies could have been an obstacle to progress because of the varied approaches the contracting agencies used for intake. It was essential that a referral process be developed that accommodated the providers' differences, yet did not create problems for others (e.g., CAPS Coordinators, youth, families, etc.) involved in the process. Each Work Group member identified how their intake system worked generally, but more importantly, outlined how intake would work particularly for CAPS referrals.

The Work Group agreed to convene screening meetings to determine the appropriateness of referrals. This guaranteed that appropriate cases would be identified before involving interagency service team members. This procedure both refined and expedited the referral process, and also greatly reduced the possibility of losing a child or youth with emotional problems at intake. Further, the Work Group members discussed what "priority access" meant operationally to the contract agencies. The Work Group also identified the development of a referral process from the larger children's social service community to the project as a top priority.

4. Confidentiality

Another procedural issue that was resolved by the Work Group involved the release of confidential information. Interagency linkages and lines of communication are necessary because (except in rare cases) no agency is capable

of meeting the needs of emotionally handicapped children in isolation. However, sharing sensitive information is not something that can be informally pursued, because most administrators fear the possibility of lawsuits resulting from the abrogation of mandated confidentiality. The existing release of information policies among the contract agencies were not standardized to the point that Work Group members could promise the transfer of information without prior approval from their boards, attorneys and agency directors.

The County's attorney developed a release authorization form that was eventually agreed upon by all provider agencies. This allowed the agencies to collaborate, brief one another as to relevant information, review prior intervention, and ultimately develop the interagency or CAPS Team service plan. This document was approved by the legal representatives of provider agencies; even though it was time consuming, this was a very necessary activity. Copies of this and other CAPS forms are contained the Appendix.

III. The CAPS Service Teams Implementing the Project

A. The CAPS Team

By design, the CAPS approach established an interagency service team around the child which was to extend beyond the intra-agency service teams employed at the time by the contract agencies. An important consideration in the development of the team process was the ability to recruit and draw upon the experience, wisdom, and expertise of those in other agencies working on behalf of children with emotional problems. In the formation of each CAPS Service Team the CAPS coordinators identified all agencies and individuals who were currently providing or who had previously provided services to the child. This focus contributed to the development of comprehensive and integrated service plans.

In considering the range of services needed for these children and youth,

it was recognized that many other services and resources, in addition to mental health services per se, could be coordinated to positively affect mental health in youth and children. For example, agencies such as Adult and Family Services (AFS), Children's Services Division (CSD), the Juvenile Court, the Private Industry Council (PIC), youth service centers, and the Park Bureau could be integrated into a system of care in order to enhance and support a CAPS service plan.

It was essential for the CAPS Coordinators to make outreach efforts to a variety of community based service providers who could be potential CAPS Service Team members. These agencies or individual participants were not compensated monetarily for their involvement with CAPS. However, their support was solicited with the idea that mutual service goals could be met through collaboration and coordination to establish systems of service or continuums of care for youth and children with emotional handicaps.

In time, cooperation with CAPS led to more rapid and less obstructed access to services, reduced duplication and fragmentation, and delivery of comprehensive services. Moreover, these agency's efforts were themselves enhanced by the activities of the interagency service team. In this light, participation of non-compensated agencies on the CAPS Service Teams benefited both the client and family as well as the agencies themselves.

B. Clarifying Roles

As the CAPS Project began to unfold it was important to delineate the respective roles of CAPS Service Team members. In particular, the roles of the CAPS Coordinator, the provider agencies and the case coordinator were identified.

The CAPS Coordinators, as seen originally by the Multnomah County School Mental Health Program, were to have three primary functions:

1. Coordinating the assembly and continuity of the inter-agency service team for each child;

2. Serving as a primary provider of mental health services for some children; and

3. Serving as a secondary provider of mental health or mental health related services for some children.

The assumption of these functions required that the CAPS Coordinator possess skills in affiliation building, skills in case management, and skills in providing direct services to emotionally handicapped children and youth.

The CAPS Coordinators also had to be politically astute, systems oriented, and adept at group management. The interagency service team was, by design, unique to each child and the job of the CAPS Coordinator was to assemble the teams, and facilitate consensus around a service plan. This was not always a simple task. Some of the agencies represented on the teams often had unpleasant histories with each other, or no history at all in providing integrated service delivery.

The CAPS Coordinators were central and indispensable to the success of the project in its first year. They spent considerable time on pre-meeting and post-meeting activities. Typically, this involved briefing and de-briefing interagency team members. Pre- and post-meeting activities were essential for soliciting participation by both contract and autonomous agencies, but it also helped focus the team's activities and resolves. Coordination of the initial meeting and review meetings was demanding; however, fully coordinated initial and review meetings were a critical element in securing and maintaining the voluntary participation of the many autonomous agencies providing services to children and youth in and around the County.

A case coordinator was identified for each CAPS team. The role of this person was to assemble the team, schedule reviews, keep in communication with team members, and be responsible for facilitating the discussions during team meetings. Initially, the CAPS Coordinators also served as case coordinators. As the project gained experience with the process however, the CAPS service

teams chose their own case coordinators thus allowing the CAPS Coordinators to continue work on initiating new teams. (See Recommendations below.)

The CAPS coordinators also were engaged in community marketing and outreach. They developed an information and referral packet for agencies who referred children to the project (see Appendix) and presented information on the CAPS project in person to various child serving agencies in the community.

C. Accountability

At the project level, the CAPS Work Group designed accountability forms which identified timelines, delegated responsibilities of the case coordinator, of the CAPS Coordinator, and tasks to be completed. Using this form and keeping it with the case record provided a built-in accountability measure. (See Appendix)

At the CAPS Service Team level, the review meetings themselves were the primary mechanism for accountability. As long as the review meetings were held, accountability was maintained through professional integrity, peer pressure, and a commitment to the CAPS concept. This, of course, illustrates why an initial understanding of the CAPS concept by all the participants was so important.

D. Characteristics of CAPS Referrals

Thirty-five referral packets were received by CAPS between January 1, 1986 and June 30, 1986. Of the thirty-five, twenty-four were formally accepted for CAPS services. Of the eleven cases which were referred but were not yet participating, four were waiting for decisions on eligibility, four were clearly ineligible, one refused treatment, one was refused by a contract agency, and one was remanded to adult court.

Of the twenty-four cases accepted for CAPS services, fourteen were existing cases already receiving services from one of the five children's mental health service agencies. Of these twenty-four cases, ten were from out-of-home placements and one was living with a relative. For all thirty-five cases referred for screening, twenty-one were sent by community mental health centers,

six by schools or the school mental health program, five by the Children's Services Division, and three by hospitals.

E. Summary

Perhaps the most significant accomplishments of the CAPS Project in FY 85-86 are not revealed numerically. A major accomplishment was designing the project itself. This was done through the CAPS Work Group over a period of several months. It was not easy to reach consensus or to develop compromises that were mutually acceptable. However, after a year of struggle and development, the Project has evolved into a credible and viable program. The interaction that took place in FY 85-86 allowed the CAPS Project to routinize and standardize how the CAPS Teams will operate. Further, this interaction should greatly enhance the degree and facility of interagency collaboration and cooperation.

IV. Recommendations

In discussing the CAPS project and this evaluation with its participants, several recommendations emerged. We include them here for consideration by others who may be designing similar projects in their communities.

The project staff may need to mount an aggressive public awareness effort. While the CAPS Coordinators should be credited with soliciting the support of autonomous agencies, there was still more community education about the project needed. It is possible that, with the production of printed materials such as brochures or pamphlets and an outreach campaign to agencies and community based organizations, CAPS could have increased its support base considerably. A concerted public awareness approach would present to the general public some of the problems faced by seriously emotionally handicapped children and their families and how both formal and informal resources can be utilized to establish a continuum of care. Also, from an interorganizational perspective, increased

awareness could acquaint non-contracted agencies with CAPS criteria, services, and team processes, thus preparing them for eventual participation on a CAPS service team.

Both the printed materials and outreach aspects of public awareness can help develop a needed expansion of the continuum of care network. Agencies such as the Private Industry Council, the Juvenile Court, the Park Bureau, Health Services, Youth Service Centers and other youth serving agencies potentially can play a vital role in providing service and participating on a CAPS Service Team for a given case. Informal resources and supports such as extended family, religious organizations, philanthropic organizations, fraternal groups, self-help and advocacy networks can give the CAPS team, as well as the service plan, a more community-based perspective.

The details of the CAPS Coordinators' role may need to be reconsidered. The Coordinator assumes a posture of neutrality or objectivity by not being a direct service provider who may have a vested interest in a CAPS case. This neutrality is preferred by agency representatives and staff. It makes the process of accessing services or soliciting support from them easier. The concern is that if the CAPS Coordinators assume direct service responsibilities they may compromise their ability to network with autonomous agencies. When assembling and facilitating the CAPS Service Teams, neutrality on the case is an important aspect of coordinating the activities of diverse individuals and the various agencies they represent.

In the future, it may not be possible for CAPS Coordinators to attend ongoing review meetings given their primary responsibilities. This situation becomes even more acute if CAPS Coordinators invest more time in public awareness or community outreach campaigns. So the issue of the CAPS Coordinator serving also as case coordinator is critical. The concern is that if case coordination becomes the responsibility of the CAPS Coordinators, then the

systems level duties that the project hinges upon may suffer.

CAPS teams should perform termination planning to assure that client progress made during CAPS' involvement has a greater chance of being sustained. In addition, termination planning presents an opportunity to evaluate the success or drawbacks of interagency service delivery for this population of children and their families.

CAPS should become involved in establishing written interagency agreements. Based on the service objectives of various agencies, agreements could be developed through negotiations with the MED Program Office to satisfy service goals held in common among prospective service providers. Among other benefits, these agreements can serve to reduce administrative services, refine and expedite referral and intake processes, and generally assure the involvement of and support by relevant agencies and organizations.

The definition of the target population may require revision. The current definition is still perceived by some as weighted in favor of enhancing services for children returning to community placements from residential treatment programs. One person recommended that perhaps at least an equal emphasis should be placed on children at risk of placement in residential treatment facilities. This recommendation points out that the dispute over whether preventive or rehabilitative services should receive priority has not yet been resolved. It represents an enduring tension within the field of children's mental health services.

Families and parents need to be more involved in the CAPS teams. It is important that this occur so that gains made in areas of treatment and coordination are shared with those who have the ultimate responsibility for the child. To exclude parents, foster parents and extended family members from the planning for the child precludes the development of a viable system of care.

The Therapeutic Case Advocacy Project is one of several endeavors of the Research and Training Center to Improve Services for Seriously Emotionally Handicapped Children and Their Families. Other Center efforts include the Families as Allies Project and the Youth in Transition Project. The Center also has a Resource Service, which publishes a quarterly newsletter, Focal Point, and disseminates Center materials. The Center is part of the Regional Research Institute for Human Services of the Graduate School of Social Work at Portland State University.

For further information about the Research and Training Center or its materials, please contact:

Marilyn McManus
Resource Services Coordinator
Research and Training Center to Improve Services
for Seriously Emotionally Handicapped Children
and Their Families
Regional Research Institute for Human Services
Portland State University
P.O. Box 751
Portland, Oregon 97217

(503) 229-4040

For further information about the CAPS Project, please contact:

Davene Cohen
Program Specialist
Multnomah County Mental Health
426 S. W. Stark (6th Floor)
Portland, Oregon 97204

(503) 248-3031

APPENDIX

MULTNOMAH COUNTY OREGON

DEPARTMENT OF HUMAN SERVICES
SOCIAL SERVICES DIVISION
SCHOOL MENTAL HEALTH PROGRAMS
426 S.W. STARK, 6TH FLOOR
PORTLAND, OREGON 97204
(503) 248-3031

DENNIS BUCHANAN
COUNTY EXECUTIVE

April 1986

RE: CAPS Team Project

Dear colleague,

The attached sheet provides information about the CAPS Team Project. It describes the project intent, eligibility and services provided.

The CAPS Team is a demonstration project designed to facilitate access to mental health and social services and assure a system of care. The population served is children and adolescents with multiple needs and multiple agency involvement.

The CAPS Team consists of a group of individuals from involved agencies who meet together in order to establish a unified effort on behalf of a youth. The team develops a comprehensive service plan, shares responsibilities for implementation of the plan and re-convenes at regular intervals to evaluate progress and form new objectives.

CAPS will primarily focus on assisting emotionally disturbed children and adolescents who are leaving treatment facilities or who have been placed out-of-home, and are in need of transition support and mental health treatment. Other youth who are in need of a more comprehensive networking approach and mental health services will also be considered for the project.

To obtain a referral packet, or further clarification about the intent and eligibility of the project, call Tracy Waters, M.S.W. or Sheri Teasdale, M.S.W. at 248-3031.

1439Y-1

MULTNOMAH COUNTY MENTAL HEALTH CAPS TEAM PROJECT

Description of Project: Multnomah County has received some additional funds to provide services for a limited number of children and adolescents requiring more than one type of service, where mental health treatment is one of the service needs, and where a more integrated service plan is needed involving the networking of services provided by the School Mental Health Program, Multnomah County mental health sub-contract agencies, and other social, justice, and educational agencies.

Eligible Children:
Target children and adolescents will be selected from the following high-risk populations:

* Children who have experienced multiple out-of-home placements.
* Victims of abuse, neglect, parental death, and custody shifts.
* Children presenting symptoms of mental disorder, who are at risk of removal from school and/or home.
* Children whose parents are: chronically mentally ill, acutely mentally disabled, substance abusers, or in the correctional system.
* Children exhibiting impaired relationship capacity or bizarre behavior.

In addition, the children and adolescents eligible for the CAPS Team Project will be those who:

* Have a need for mental health services as documented by a qualified mental health professional.
* Will benefit from networking services from mental health, social, justice and educational agencies and are eligible to attend a publicly funded school.
* Present one or more of the following characteristics:
  1. are currently placed out-of-home
     or
  2. have returned to the community within the last six months
     or
  3. require transition support to sustain intervention gains or maintain current placement.

What the Child Will Get: Children and their families who are referred will initially be screened through an area CAPS Team comprised of a school mental health consultant, the appropriate school building representative, the area community mental health agency representative and representatives from other relevant agencies. When a child and his/her family has been accepted for service, they are assured the following:

* Guaranteed priority access to one of the following treatment resources:
  1. The Center for Community Mental Health
  2. Delaunay Mental Health Center
  3. Mental Health Services West Childrens Program
  4. Morrison Center (Portland and East County Centers)
  5. School Mental Health Program
* The CAPS Team's assistance in developing a comprehensive, integrated service plan.
* A designated primary case manager who will serve as an advocate in behalf of the child and family to guarantee that the service plan is carried out.
* The CAPS Team's support of the service plan including regular reviews as to the plan's effectiveness.

REFERRAL PROCESS CHECKLIST:

☐ 1. Contact a CAPS Coordinator by phone to talk about the referral. Call 248-3031 and ask for Sheri Teasdale, M.S.W., or Tracy Waters, M.S.W.

☐ 2. Complete referral forms, obtain release of information, attach available assessments and reports and send packet to:

CAPS Team Coordinator
School Mental Health Program
426 S.W. Stark, 6th Floor
Portland, OR 97204

☐ 3. Complete presentation guidelines and save for use at team meeting.

4. Referral reviewed by CAPS Coordinator

5. CAPS team meeting is scheduled by CAPS Coordinator

☐ 6. Referring person presents case to CAPS team

[FM-4000S-1/p]

CAPS TEAM
REFERRAL PACKAGE

Referred by:
Agency Name _____ Date _____
Presented by _____ Phone _____

Name of Child _____ DOB _____ Age _____ Sex _____

Current Address _____ Phone _____

Living With _____ Relationship _____

Custody With _____ Relationship _____

Custodian Address _____ Phone _____

Current School _____ Grade _____ Phone _____

Attending _____ _____ _____
Yes No Other - Explain

Needs (Services and resources - not agencies) _____

Agencies Currently Involved with Child:

1. a) School _____ Contact _____ Phone _____
   b) School _____ Contact _____ Phone _____

2. Agency Name _____ Worker _____ Phone _____
   Services Provided _____

3. Agency Name _____ Worker _____ Phone _____
   Services Provided _____

4. Agency Name _____ Worker _____ Phone _____
   Services Provided _____

5. Agency Name _____ Worker _____ Phone _____
   Services Provided _____

Waiting List for Additional Services or Resources:

Agency Name _____ Address _____ Phone _____
Services Needed _____ Available (Est.)_____

4140S-1

PERTINENT FAMILY HISTORY AND OBSERVATION: (May be substituted by attaching agency report on family history).

NAME OF PARENTS:

NAME: _____ Phone: _____

Address: _____

NAME: _____ Phone: _____

Address: _____

CURRENT FAMILY CONSTELLATION (Grandparents, etc.):

_____

_____

PARENT HISTORY (Examples: cultural, economic, education, and religious):

_____

_____

_____

FAMILY MENTAL HEALTH (Examples: schizophrenic, hospitalizations, suicides):

_____

_____

FAMILY MEDICAL HISTORY (Examples: diabetes, alcoholism).

_____

_____

_____

ADDITIONAL COMMENTS (Examples: assessment of family functioning, assessment of family as resource to child and to treatment).

_____

_____

_____

_____

_____

Evaluations and Reports Available

1. Medical _____ Dated _____
   (By Whom)

2. Psychological _____ Dated _____
   (By Whom)

3. Psychiatric _____ Dated _____
   (By Whom)

4. Neurological _____ Dated _____
   (By Whom)

5. Educational _____ Dated _____
   (By Whom)

6. Psychosocial _____ Dated _____
   (By Whom)

7. Family History _____ Dated _____
   (By Whom)

8. Other _____ Dated _____
   (By Whom)

9. Other _____ Dated _____
   (By Whom)

Educational Background

Handicapping Condition _____Yes _____No What _____

IEP _____Yes _____No

Special Programs: _____

_____

Academic Performance: _____

_____

School Behavior (Problem/Specify Setting): _____

_____

Additional Comments: _____

_____

_____

_____

4140S-2

Descriptive Summary of Child: This section should include information regarding areas of strengths and weaknesses, and current level of functioning. Example issues may include: Who has the child responded to? Identify significant others within and outside the family? Child's views, wants, and motivations? Church, club, or organizational affiliations? Who cares about this child? How does the child feel about self? Outward appearance? Typical response to stress, anxiety, or crisis? Peer relationship management? How would you describe the child's overall mental state?

MULTNOMAH COUNTY OREGON

DEPARTMENT OF HUMAN SERVICES
SOCIAL SERVICES DIVISION
SCHOOL MENTAL HEALTH PROGRAMS
426 S W STARK. 6TH FLOOR
PORTLAND OREGON 97204
(503) 248-3031

DENNIS BUCHANAN
COUNTY EXECUTIVE

CAPS SERVICE TEAM

AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION

The purpose of this Authorization form is to enable agencies identified below to better serve your child through coordinated service planning and delivery. Representatives of identified agencies will meet and share information regarding your child at scheduled planning and review meetings.

The CAPS Service Team for your child shall include the following agencies:

/__/ CAPS/School Mental Health Program

/__/ Juvenile Court

/__/ _____
Child Mental Health Provider

/__/ _____Youth Service Center

/__/ _____School District

/__/ _____
Inpatient M.H. Facility

/__/ Childrens' Services Division

/__/ _____
Other

I authorize the release and exchange of information between and among the identified CAPS Team Members which will be planning services for _____. This release authorizes a free exchange of
child's name
information between members for the purpose of diagnosis and treatment. It does not authorize release to any other person or agency except those agencies listed above. Unless revoked in writing this release and exchange shall remain in force as long as child remains in CAPS program.

_____ _____
Witness Authorizing Signature

_____ _____
Date Relationship to Child

1680Y

For presenter use only

CAPS TEAM PRESENTATION GUIDELINES

Please be assured that the committee has reviewed the referral material that you submitted regarding the child. In the interest of all concerned, would you please present to the committee using the following format:

1. Brief summary of child's strengths and weaknesses. (High intelligence/impulsive/easily angered).

2. Brief summary of child's primary and secondary problems. (Alcoholism/limited shelter availability).

3. Brief summary of child's placements and reason for success or failure.

4. What service, treatment, or program elements are needed to serve this child?

5. Share your thoughts for an optimal plan for this child. Creativity and flexibility are needed options.

[EN4073Sp]

CAPS TEAM
426 S.W. Stark
Portland, OR 97204
248-3031

COOPERATIVE WORK AGREEMENT

As an interagency service plan development and monitoring team, the CAPS Team reviews confidential information on children and adolescents referred to the project. In carrying out this networking of services and case planning, the agencies and persons below commit to work cooperatively together on behalf of _____ and his or her family, and to keep confidential all information disclosed.

Name:	Agency:	Date:

1717Y

CAPS TEAM

INTERAGENCY SERVICE PLAN

Client:_____ Next Review Meeting:

Case Coordinator:_____ _____

Team Participants: Date:_____ _____

Name:	Agency:	Phone:
1.		
2.		
3.		
4.		
5.		
6		

GOAL:_____

Issue:	Action to be taken:	Who:	Result:

CAPS TEAM

INTERAGENCY SERVICE PLAN REVIEW

Client: _____ Next Review Meeting:

Case Coordinator: _____ _____

Date: _____ _____

GOAL: _____

_____

_____

Issue:	Action to be taken:	Who:	Result:

THE MULTNOMAH COUNTY CAPS PROJECT: AN EFFORT TO COORDINATE SERVICE DELIVERY FOR CHILDREN AND YOUTH CONSIDERED SERIOUSLY EMOTIONALLY DISTURBED

EVALUATION FORM

1. Who used *The Multnomah County CAPS Project*? (Check all that apply.)

   ___Parent ___Educator ___Child Welfare Worker

   ___Juvenile Justice Worker ___Mental Health Professional

   Other (Please Specify) _____

2. Please describe the purpose(s) for which you used the process evaluation:

   _____

   _____

3. Would you recommend use of *The Multnomah County CAPS Project* to others?

   (Circle one)

   Definitely Maybe Conditionally Under No Circumstances

   Comments: _____

4. Overall, I thought *The Multnomah County CAPS Project* was: (Circle one)

   Excellent Average Poor

   Comments: _____

5. Please offer suggestions for the improvement of subsequent editions of *The Multnomah County CAPS Project*:

   _____

   _____

   _____

   _____

We appreciate your comments and suggestions. Your feedback will assist us in our effort to provide relevant and helpful materials. Thank you.

Please fold, staple and return this self-mailer to the address listed on the reverse side.

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PORTLAND STATE UNIVERSITY
P.O. BOX 751
PORTLAND, OR 97207

Research and Training Center Resource Materials

- ☐ *Annotated Bibliography. Parents of Emotionally Handicapped Children: Needs, Resources, and Relationships with Professionals.* Covers relationships between professionals and parents, parent self-help, support and advocacy groups, parent participation, parents' problems and guidelines. $7.50 per copy.

- ☐ *Annotated Bibliography. Youth in Transition: Resources for Program Development and Direct Service Intervention.* Transition needs of adolescents: educational and vocational issues, programs and curriculum, research overviews, interpersonal issues, skills training. $6.00 per copy.

- ☐ *Child Advocacy Annotated Bibliography.* Includes selected articles, books, anthology entries and conference papers written since 1970, presented in a manner useful to readers who do not have access to the cited sources. $9.00 per copy.

- ☐ NEW! *Choices for Treatment: Methods, Models, and Programs of Intervention for Children With Emotional Disabilities and Their Families. An Annotated Bibliography.* The literature written since 1980 on the range of therapeutic interventions used with children and adolescents with emotional disabilities is described. Examples of innovative strategies and programs are included. $6.50 per copy.

- ☐ *Families as Allies Conference Proceedings: Parent-Professional Collaboration Toward Improving Services for Seriously Emotionally Handicapped Children and Their Families.* Held in April 1986 and attended by delegations from thirteen western states. Includes: agenda, presentation transcriptions, biographical sketches, recommendations, worksheets, and evaluations. $7.50 per copy.

- ☐ *Gathering and Sharing: An Exploratory Study of Service Delivery to Emotionally Handicapped Indian Children.* Findings from Idaho, Oregon, and Washington, covering current services, successes, service delivery barriers, exemplary programs and innovations. $4.50 per copy.

- ☐ *Glossary of Acronyms, Laws, and Terms for Parents Whose Children Have Emotional Handicaps.* Glossary is excerpted from the *Taking Charge* parents' handbook. Approximately 150 acronyms, laws, and words and phrases commonly encountered by parents whose children have emotional disabilities are explained. $3.00 per copy.

- ☐ NEW! *Interagency Collaboration: An Annotated Bibliography for Programs Serving Children With Emotional Disabilities and Their Families.* Describes local interagency collaborative efforts and local/state efforts. Theories of interorganizational relationships, evaluations of interagency programs, and practical suggestions for individuals contemplating joint programs are included. $5.50 per copy.

- ☐ *Making the System Work: An Advocacy Workshop for Parents.* A trainers' guide for a one-day workshop designed to introduce the purpose of advocacy, identify sources of power and the chain of command in agencies and school systems, and practice advocacy techniques. $8.50 per copy.

- ☐ *The Multnomah County CAPS Project: An Effort to Coordinate Service Delivery for Children and Youth Considered Seriously Emotionally Disturbed.* A process evaluation of an interagency collaborative effort is reported. The planning process is documented and recommendations are offered. $7.00 per copy.

- ☐ NEW! *National Directory of Organizations Serving Parents of Children and Youth with Emotional and Behavioral Disorders.* The 344 U.S. organizations in the second edition provide one or more of the following services: education and information, parent training, case and systems level advocacy, support groups for parents and/or brothers and sisters, direct assistance such as respite care, transportation and child care. $8.00 per copy.

- ☐ *Parents' Voices: A Few Speak for Many* (videotape). Three parents of children with emotional disabilities discuss their experiences related to seeking help for their children (45 minutes). A trainers' guide is available to assist in presenting the videotape. Free brochure describes the videotape and trainers' guide and provides purchase or rental information.

- ☐ *Respite Care: An Annotated Bibliography.* Thirty-six articles addressing a range of respite issues are summarized. Issues discussed include: the rationale for respite services, family needs, program development, respite provider training, funding, and program evaluation. $7.00 per copy.

- ☐ *Respite Care: A Monograph.* More than forty respite care programs around the country are included in the information base on which this monograph was developed. The monograph describes: the types of respite care programs that have been developed, recruitment and training of respite care providers, the benefits of respite services to families, respite care policy and future policy directions, and a summary of funding sources. $4.50 per copy.

- ☐ *Taking Charge: A Handbook for Parents Whose Children Have Emotional Handicaps.* The handbook addresses issues such as parents' feelings about themselves and their children, labels and diagnoses, and legal issues. The second edition expands upon emotional disorders of children, including post-traumatic stress disorder and mood disorders such as childhood depression and bipolar disorder. $7.00 per copy.

More listings and order form on reverse ☞

☐ NEW! *Transition Policies Affecting Services to Youth With Serious Emotional Disabilities.* The monograph examines how state level transition policies can facilitate transitions from the child service system to the adult service system. The elements of a comprehensive transition policy are described. Transition policies from seventeen states are included. $5.75 per copy.

☐ *Working Together: The Parent/Professional Partnership.* A trainers' guide for a one-day workshop for a combined parent/professional audience. Designed to identify perceptions parents and professionals have of each other and obstacles to cooperation; as well as discover the match between parent needs and professional roles, and practice effective listening techniques and team decision making. $8.50 per copy.

☐ NEW! *Youth in Transition: A Description of Selected Programs Serving Adolescents With Emotional Disabilities.* Detailed descriptions of existing youth transition programs are provided. Residential treatment, hospital and school based, case management, and multi-service agency transition programs are included. Funding, philosophy, staffing, program components, and services information is provided for each entry. $6.50 per copy.

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