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ABSTRACT

This document presents the proceedings of the 8th Annual (1996) Children's Mental Health Conference. Eleven main sections focus on the following topics: (1) evaluation efforts within states and systems of care; (2) financing strategies of systems of care; (3) family participation; (4) school-based services; (5) the child welfare system; (6) the juvenile justice system; (7) case management services; (8) models to improve service delivery; (9) early intervention approaches; (10) research methodology and information systems; and (11) utilization research. Also included are two lectures in the Gwen R. Iding Brogden Distinguished Lecture Series: "New Approaches to Evaluating Systems" (Heather B. Weiss) and "Outcome Accountability and System Reform: What Should They Mean in Policy and Practice?" (Charles Bruner). (DB)

A System of Care for Children's Mental Health: Expanding the Research Base. Proceedings of the Annual Research Conference (8th, Tampa, FL 1996).

Cindy Liberton, ed.
Krista Kutash, ed.
Robert M. Friedman, ed.

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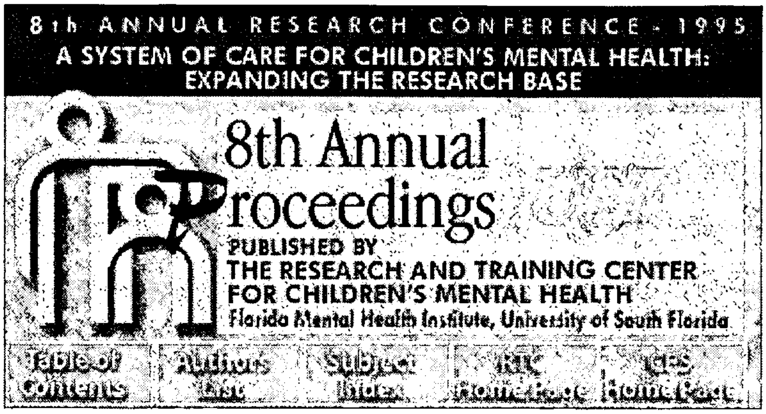

8th ANNUAL RESEARCH CONFERENCE - 1995
A SYSTEM OF CARE FOR CHILDREN'S MENTAL HEALTH:
EXPANDING THE RESEARCH BASE

8th Annual
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Table of Contents◆Authors List◆Subject Index
RTC Home Page◆CFS Home Page◆Other FMHI Sites◆USF

8th Annual Children's Mental Health Research Conference Proceedings

CONTENTS

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Go Back

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies,
Florida Mental Health Institute, University of South Florida,1996

Table of Contents
8th Annual Research Conference Proceedings

Chapters:◆1◆2◆3◆4◆5◆6◆7◆8◆9◆10◆11
◆Gwen Iding Lecture Series

◆Go to Authors Index
◆Child & Family Studies ◆CFS Divisions ◆Faculty and Staff
◆ResourceNet ◆Other FMHI Sites ◆University of South Florida

Chapter 1
Focus on Evaluation Efforts within States and Systems of Care

---

◆Return to Chapter List ◆Go to Authors List Go to Top of Page

---

Chapter 2
Focus on Financing Strategies for Systems of Care

◆Return to Chapter List ◆Go to Authors List Go to Top of Page

---

Chapter 3
Focus on Family Participation

◆Return to Chapter List ◆Go to Authors List Go to Top of Page

---

Chapter 4
Focus on School-based Services

◆Return to Chapter List ◆Go to Authors List Go to Top of Page

---

Chapter 5
Focus on the Child Welfare System

◆**Return to Chapter List** ◆**Go to Authors List** **Go to Top of Page**

Chapter 6
Focus on the Juvenile Justice System

◆**Return to Chapter List** ◆**Go to Authors List** **Go to Top of Page**

Chapter 7
Focus on Case Management Services

◆**Return to Chapter List** ◆**Go to Authors List** **Go to Top of Page**

Chapter 8
Focus on Models to Improve Service Delivery

◆**Return to Chapter List** ◆**Go to Authors List** **Go to Top of Page**

Chapter 9
Focus on Early Intervention Approaches

◆**Return to Chapter List** ◆**Go to Authors List** **Go to Top of Page**

Chapter 10
Focus on Research Methodology and Information Systems

◆**Return to Chapter List** ◆**Go to Authors List** **Go to Top of Page**

Chapter 11
Focus on Utilization Research

◆**Return to Chapter List** ◆**Go to Authors List** **Go to Top of Page**

The Gwen R. Iding Brogden Distinquished Lecture Series

◆**Return to Chapter List** ◆**Go to Authors List** **Go to Top of Page**

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida, 1996

An Overview of State Public Mental Health Programs for Children with a Serious Emotional Disturbance

Authors

Introduction Methods Results References
Return to Table of Contents

Introduction

Over the past decade, increasing concern has been expressed about the mental health of our children. This has been caused by a number of factors including widespread family breakdown, the growing number of children born to teen age mothers, the increasing rates of substance abuse and school dropouts. Many of these children receive no care and of those that do, many receive it from state and local public mental health agencies. Thus, it is important to examine how well the states are addressing this need.

Return to Top

Methods

The data for this report come from the individual State Federal Block Grant Plan and Implementation Reports. The Federal State Block Grant legislation, Public Law (P.L.) 102-321, requires that the states develop overall program plans and annual progress reports. The plans must address twelve criteria pertaining to the development of community based systems of care. Not surprisingly, the quality of the plans and reports varies significantly across the states as does the amount of information provided. However, these reports have improved significantly due to better management information systems, better record keeping, and the participation of State Planning Councils with consumer and family representation.

Return to Top

Results

Data from the State Federal Block Grant Plan and Implementation Reports suggest that all states have made progress in establishing an organized community based system of care for children and adolescents with serious emotional disturbances (SED) and their families. All 50 states report that they have adopted the Federal Child and Adolescent Service System (CASSP) principles for what constitutes an organized comprehensive community based system of care. These principles state that the systems should be comprehensive, coordinated, community based, family centered and culturally competent.

In some states, this system development has been further enhanced by initiatives from the Governor, state legislators and local government officials. In other states, system development is impacted by litigation, especially in regard to inappropriate hospitalization. In still other states, state laws have been enacted which mandate that systems or system components such as local interagency coordinating councils be developed.

Furthermore, all the states report efforts to develop interagency collaborations, usually with state and local education, health, child welfare and juvenile justice agencies. Children's mental health service agencies are now linked with child welfare and social service agencies in 48 states, with educational agencies in 44 states, with juvenile justice agencies in 28 states and with health agencies in 28 states.

Family Support

There has been significant growth in family support and family preservation activities. In 1993, Congress passed legislation that, for the first time, made a significant investment in preventive services aimed at keeping families together. This legislation, known as the Family Support and Preservation Act, passed as part of the Omnibus Budget Reconciliation Act (OBRA) of 1993 (P.L. 103-66). As such, it was the first major new child welfare legislation in over a decade. In 1994, family preservation home builder programs were established in 35 states, and statutes addressing family preservation in 21 states.

Concomitant with this, there has been tremendous growth in the movement to establish grass routes family support groups throughout the country.

Serving Children with SED

States reported serving an increased number of children with SED. The "most in need" target population included those persons under 18 years old who had a mental illness; that is, had a DSM-III R diagnosis, experienced serious functional impairment, had multi agency involvement, and whose illness duration has been greater than one year. Estimates of the prevalence of SED among children vary from 2-5% to 12% of the child population. While there are varying estimates of need and demand for services, for the purpose of this report the most conservative estimates will be used; that is that 2% of all children under age 18 have a SED, and that 1.2% of all children under 18 are estimated to need services for SED from the public sector at any given point in time.

In an attempt to assess state programs in regard to how many children with SED they serve, these numbers were examined on a state-by-state basis. In examining these data, it was clear that there was great variation across the states in the numbers of children with SED served in comparison to the conservative estimates of target populations. The reports of percent of children with SED served ranged from 8 to 100%. Moreover, 14 states exceeded the proportion of children estimated to need services in the public sector in FY 1993-1994 (see Table 1). Another six states came close to these targets. These states included Alabama, Georgia, Indiana, Kentucky, Maine and South Dakota.

Development of Community Based Services

States also reported progress in developing community-based service arrays to substitute for inpatient care. According to the Block Grant Reports, the community based services for which there was the greatest demand and need were respite, crisis care and home-based services, as well as flexible wraparound services. Moreover, in order to further improve access, more and more states reported initiatives to provide services in schools and provide single points of service system entry.

The major financing sources reported were private insurance and/or foundation money, Medicaid, and funds from state and local jurisdictions. At a national level, private sources funded about 44% of care, with Medicaid funding 19% and state and local jurisdictions funding 28%. During the 1980's Medicaid expenditures grew faster than private insurance expenditures.

Medicaid eligibility procedures appear to have benefited state mental health programs in many ways. Requirements for pre-admission screening for hospitals may have prevented inappropriate admissions. Additionally, most states reported the ability to obtain Medicaid reimbursement for case management and rehabilitation services. Furthermore, many states have or are in the process of obtaining Medicaid waivers, despite the outcome of the national health care reform legislation.

Use of Inpatient Hospital Services

States report varying degrees of success in reducing use of hospital services, with admission rates ranging from 0 per 100,000 children, to over 100 per 100,000 children. The states with the highest rates and the ones with the lowest rates are displayed in Table 2. While some states reported success in reducing their hospital use, others have not been successful, and still others had mixed results. The states which report success number almost 25, and attribute the decrease in use to closing state hospitals and/or reducing the number of beds for children, and developing alternative sources of care. However, seven states have experienced increasing rather than decreasing use of hospital care. Connecticut, Idaho, Louisiana and Tennessee, report mixed results. For example, in Idaho, the number of admissions declined, but total number of bed days and average length of stay increased. Other mixed results included those states in which the past declines in use had leveled off and/or reversed direction over the past year. These data are presented in Table 3.

To explain these varying degrees of success, the availability of alternative community services was examined, including the reported number of case managers and rate of screening for hospital admission, along with the number and array of alternative facilities, such as residential treatment centers (RTCs) and therapeutic foster and group homes. In California, for example, RTCs and groups homes were often used in lieu of hospitals.

Case Management

Reports indicated that Case Management was present in all states but Wyoming, which was in the process of developing this service. The percent of children with SED who received case management services ranged from about 8% to 100%. As can be seen in Table 4, 15% or fewer such children received case management in 11 states, whereas 50% or more of the children with SED received case management services in 10 other states. When this is compared to the conservative 1.2% estimate of children who need to use publicly funded services for SED, there appeared to be somewhat of an inverse relation between the states who reported the highest percent of children with SED served, and the proportion of those who receive case management. It appeared that the higher the proportion of children with SED who receive services, the lower the proportion who receive case management (Table 5). Of course, these data do not take into account differing case management models and client ratios.

Programs for Homeless Children

Programs for Homeless Children with SED were examined across the 50 states using block grant data along with data from the Program to Assist in the Transition from Homelessness (PATH). While all or almost all of the states report having programs to address the needs of homeless families and children, not all of them addressed homeless children with SED per se, and some did not specify numbers of such children served. Instead reference was made to services for homeless families and runaway youth in general. These data, however, did indicate that Arkansas, Maine, and North Dakota spent a sizable portion of their PATH money on children with SED. Other states such as Georgia, Kentucky and Oregon had conducted or were in the process of conducting surveys to assess the number of homeless children with SED. In addition, both Kentucky and Washington have received research demonstration grants targeted to providing services for homeless children with SED.

Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

Table 1

Return to Article

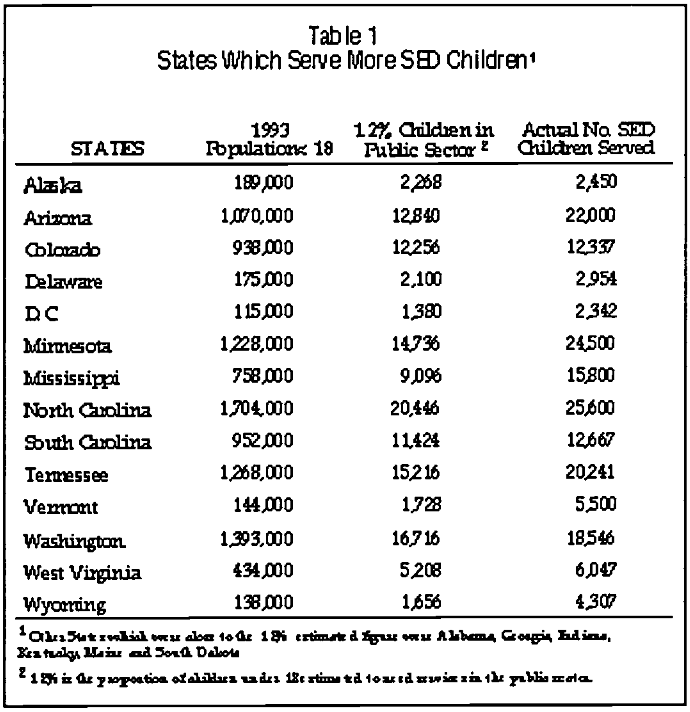

Table 1
States Which Serve More SED Children[1]

STATES	1993 Population < 18	1.2% Children in Public Sector [2]	Actual No. SED Children Served
Alaska	189,000	2,268	2,450
Arizona	1,070,000	12,840	22,000
Colorado	938,000	12,256	12,337
Delaware	175,000	2,100	2,954
D.C.	115,000	1,380	2,342
Minnesota	1,228,000	14,736	24,500
Mississippi	758,000	9,096	15,800
North Carolina	1,704,000	20,446	25,600
South Carolina	952,000	11,424	12,667
Tennessee	1,268,000	15,216	20,241
Vermont	144,000	1,728	5,500
Washington	1,393,000	16,716	18,546
West Virginia	434,000	5,208	6,047
Wyoming	138,000	1,656	4,307

[1] Other States which were close to the 1.2% estimated figure were Alabama, Georgia, Indiana, Kentucky, Maine and South Dakota

[2] 1.2% is the proportion of children under 18 estimated to need services in the public sector.

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[Home] [Search] [Index]

Table 2

Return to Article

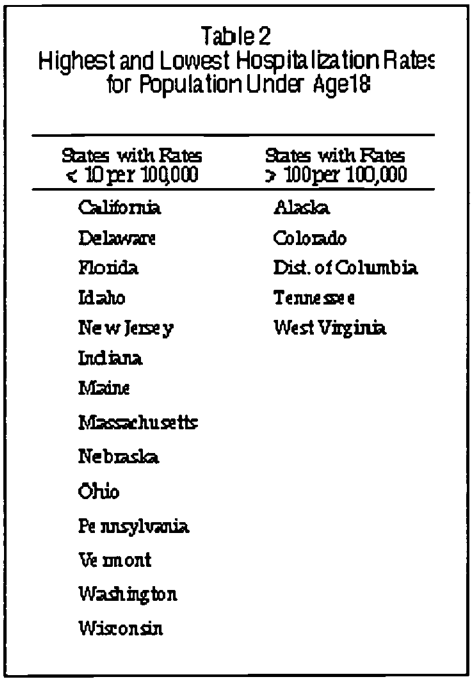

Table 2
Highest and Lowest Hospitalization Rates
for Population Under Age 18

States with Rates < 10 per 100,000	States with Rates > 100 per 100,000
California	Alaska
Delaware	Colorado
Florida	Dist. of Columbia
Idaho	Tennessee
New Jersey	West Virginia
Indiana	
Maine	
Massachusetts	
Nebraska	
Ohio	
Pennsylvania	
Vermont	
Washington	
Wisconsin	

[Home] [Search] [Index]

Table 3

Return to Article

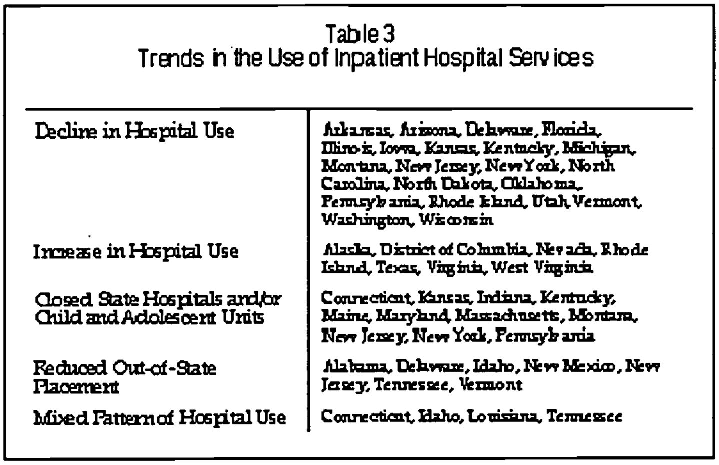

Table 3
Trends in the Use of Inpatient Hospital Services

Decline in Hospital Use	Arkansas, Arizona, Delaware, Florida, Illinois, Iowa, Kansas, Kentucky, Michigan, Montana, New Jersey, New York, North Carolina, North Dakota, Oklahoma, Pennsylvania, Rhode Island, Utah, Vermont, Washington, Wisconsin
Increase in Hospital Use	Alaska, District of Columbia, Nevada, Rhode Island, Texas, Virginia, West Virginia
Closed State Hospitals and/or Child and Adolescent Units	Connecticut, Kansas, Indiana, Kentucky, Maine, Maryland, Massachusetts, Montana, New Jersey, New York, Pennsylvania
Reduced Out-of-State Placement	Alabama, Delaware, Idaho, New Mexico, New Jersey, Tennessee, Vermont
Mixed Pattern of Hospital Use	Connecticut, Idaho, Louisiana, Tennessee

[Home] [Search] [Index]

Table 4

Return to Article

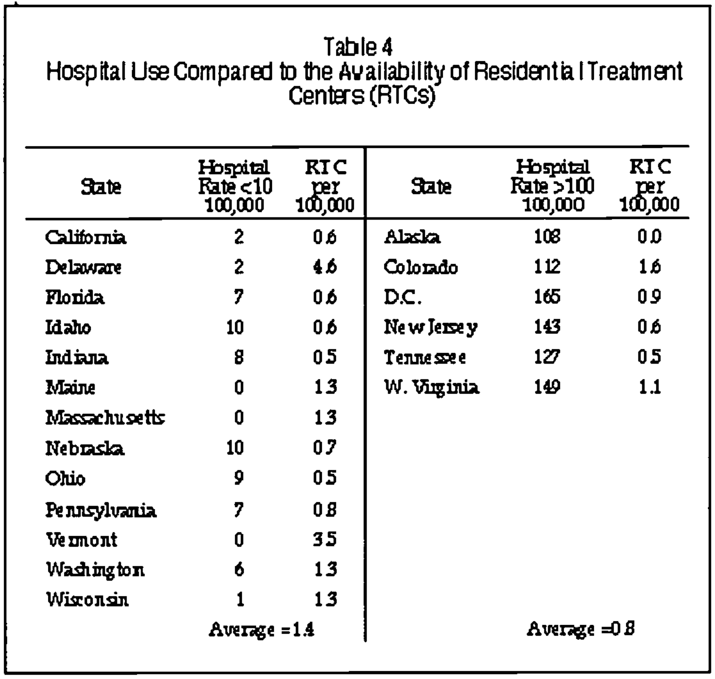

Table 4
Hospital Use Compared to the Availability of Residential Treatment Centers (RTCs)

State	Hospital Rate <10 100,000	RTC per 100,000	State	Hospital Rate >100 100,000	RTC per 100,000
California	2	0.6	Alaska	108	0.0
Delaware	2	4.6	Colorado	112	1.6
Florida	7	0.6	D.C.	165	0.9
Idaho	10	0.6	New Jersey	143	0.6
Indiana	8	0.5	Tennessee	127	0.5
Maine	0	1.3	W. Virginia	149	1.1
Massachusetts	0	1.3			
Nebraska	10	0.7			
Ohio	9	0.5			
Pennsylvania	7	0.8			
Vermont	0	3.5			
Washington	6	1.3			
Wisconsin	1	1.3			
	Average =1.4			Average =0.8	

[Home] [Search] [Index]

Table 5

Return to Article

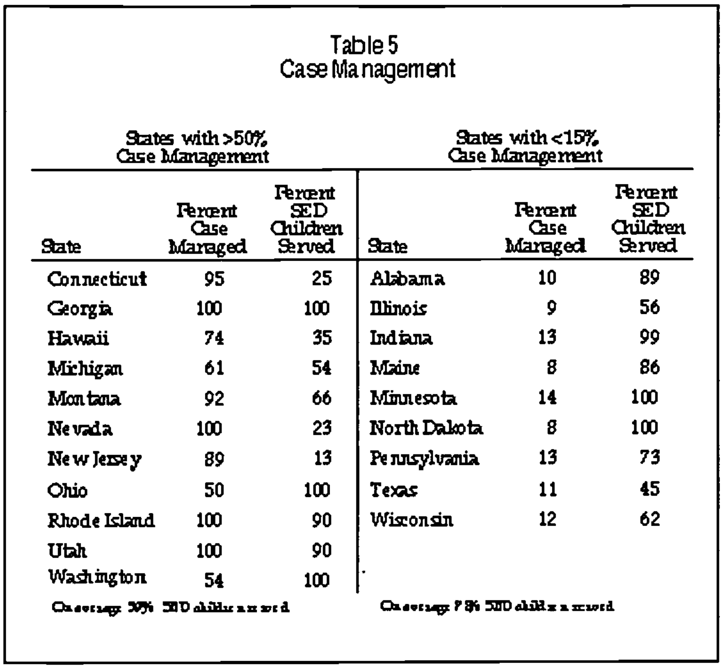

Table 5
Case Management

States with >50% Case Management			States with <15% Case Management		
State	Percent Case Managed	Percent SED Children Served	State	Percent Case Managed	Percent SED Children Served
Connecticut	95	25	Alabama	10	89
Georgia	100	100	Illinois	9	56
Hawaii	74	35	Indiana	13	99
Michigan	61	54	Maine	8	86
Montana	92	66	Minnesota	14	100
Nevada	100	23	North Dakota	8	100
New Jersey	89	13	Pennsylvania	13	73
Ohio	50	100	Texas	11	45
Rhode Island	100	90	Wisconsin	12	62
Utah	100	90			
Washington	54	100			

On average [illegible] SED children served

On average [illegible] SED children served

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health, Institute, University of South Florida, 1996

A Developmental Analysis of Neighborhood Governance: An Aspect of the Annie E. Casey Mental Health Initiative for Urban Children's Evaluation

Authors

Introduction Methods Discussion
Return to Table of Contents

Introduction

The Annie E. Casey Foundation's Mental Health Initiative for Urban Children is a five year, neighborhood scale program that seeks to demonstrate new ways of delivering comprehensive and coordinated, culturally appropriate, and family-sensitive mental health services to low income urban communities, and to work with states to improve the policies and practices supporting these services. Four urban neighborhoods in the cities of Richmond, Miami, Houston and Boston were selected to implement this initiative.

The Florida Mental Health Institute was contracted to conduct the evaluation of the Initiative's outcomes in four areas: (1) overall quality of life in the neighborhood, (2) neighborhood governance, (3) interface between family needs and system response, and (4) documentation of movement of children through the system and the budget allocations associated with these moves.

The emphasis on neighborhood governance is one of the unique aspects of the Mental Health Initiative for Urban Children which describes this as a mechanism for the delegation of real authority and decision-making from government to the neighborhood groups. This paper focuses on the outcomes of the process of neighborhood governance development including a description of the method of data collection, the creation of a developmental framework for data analysis, and a brief discussion of the findings.

Return to Top

Methodology

Data collection for the neighborhood governance study involved two methods: a survey to establish the membership, structure, and composition of the neighborhood boards; and open-ended interviews with at least two respondents from each of the following three categories: (1) board members/neighborhood residents; (2) local level personnel from organizations, agencies or community associations; and (3) State agency representatives.

Once the data were collected, a process involving review of the literature on community organizations, feedback from informal contacts with key informants at each site and formal reports from technical assistance staff working with the sites, and preliminary review of interview data led to the creation of a framework to describe governance board development. This framework depicts this development as moving along several attributes to effective administration and planning. Seven attributes were identified: (1) Community Information, (2) Community Involvement, (3) Consciousness/Knowledge, (4) Linkages, (5) Organization, (6) Programmatic Involvement, and (7) Resource Management Capacity (see attached defintitions).

Each of the attributes is divided into two or more aspects which define the attribute in more detail. For example, the attribute Consciousness/Knowledge is divided into four aspects: Belief in the Capacity to Change, Overall Vision of the Initiative, Knowledge of Human Service Systems, and Awareness of Political Process. The develop-mental stages for each aspect of an attribute include a continuum of nine stages. Stages 1, 3, 5, 7, and 9 have been defined. The intermediate stages 2, 4, 6, and 8 are not defined, but are included to allow for variance in the assignment of stages of development.

Return to Top

Discussion of Findings

The analysis has revealed significant similarities across the four sites. The overall development of neighborhood governance in three of the sites that have established Boards falls between Stages 1 and 3 across all developmental attributes. The East Little Havana site had not selected a Board at the time of the data collection for this report, and therefore, no developmental stages were assigned. The attributes of Consciousness/Knowledge, Organization, Community Involvement and Linkages have been selected for discussion in this paper.

Consciousness/Knowledge

A common element at all sites was the mixture of optimism and pessimism regarding the Board's capacity to influence the process of change in the system. Respondents at the state and local levels show varying degrees of optimism about the future of the Initiative. While they recognize the challenges that lie ahead, they also emphasize the accomplishments of having brought a diverse group of individuals together around this effort.

At the neighborhood level, however, the resident representatives on the Board are not yet confident about their chances to effect meaningful and lasting changes in service systems. Their pessimism seems to be rooted in historical factors affecting the relationships between the state, city/county, and the community. In particular, residents expressed their disappointment at other initiatives that were implemented in the past that left the community untouched and their problems unsolved. A fear that this experience may be repeated once more, combined with a sense of frustration over the lack of concrete services and programs at this point of the Initiative, are major challenges to the development of trust, a sense of partnership, and improved optimism among resident representatives on the Boards.

Another interesting trend within this attribute is the presence of several visions of the Initiative which vary depending on whether the source is the neighborhood, the local level (e.g., city, county providers), or the state level. The neighborhood's vision seems to focus on short-term expectations in the area of service delivery and program development. Neighborhood residents see this Initiative as an opportunity to bring much needed services to the community, and upgrade existing programs to better serve children and families.

The state level, on the other hand, envisions the Initiative as an opportunity to accomplish long-term system reform in the area of children's mental health. This level sees programmatic development more as a means to an end, rather than as the result of reform itself.

The local level seems to combine a short and long-term vision of the Initiative. Although, like the state, it recognizes system reform as the ultimate goal, like the neighborhood it sees the Initiative as an opportunity to supplement existing pools of money that are already being invested in the targeted communities (e.g., empowerment zones, Medicaid, full service schools, etc.). Another aspect of the local level vision is the perception of the Initiative as a chance to test the viability of new approaches to service delivery at the neighborhood level.

Organization

The most striking trend with regard to Board organization is the high degree of confusion across all sites regarding the roles of the different levels involved in the Initiative. Although in principle all parties agree that this is a community-driven effort, and that the neighborhood should be a key player and driving force, in practice, there appear to be conflicting views of the degree to which the neighborhood should be in control.

Residents perceive that their involvement should be at all levels of the decision-making process. They also express a need to catch up with the knowledge and expertise of the government level representatives, and feel frustrated when they are not treated as equal partners. Local and state level officials, on the other hand, are concerned that the community does not have the necessary expertise and experience to control the entire process.

An additional trend identified in the area of Organization relates to the distribution of labor. As a result of neighborhood representatives' need to feel included at all levels of the Initiative, the demands of serving on the Board become overwhelming. Tasks are highly concentrated on a few dedicated, politically aware volunteers who self-select themselves to be on the Board. These volunteers participate on several committees at a time, in addition to attending training events and Board meetings.

A phenomenon related to the concentration of labor on a few experienced individuals with a history of community involvement is the influence of strong personalities on the Board and among the Initiative's staff. During the initial phases of planning and implementation, all sites appear to have experienced this phenomenon to some extent, and dealt with it differently. In some cases, the identity of the Board came to be strongly tied to these individuals, leading other members to feel excluded from the process.

Community Involvement
Board representativeness is one of the biggest challenges facing all four Boards. The answer to the question of who are the Board's constituents, and therefore, to whom the Board is accountable remains elusive. Issues of representativeness cut across several lines including ethnicity, gender, age, immigration status, official status, provider status, parental status (e.g., parents of at-risk children), etc.

The data analyzed for this report suggest that some of the difficulties experienced by the Boards with regard to representativeness may be related to the type of base upon which the Boards were founded. Boards that used pre-existing organizations reportedly inherited their perceived shortcomings. In Boston, the Healthy Boston Coalition's perceived inadequate inclusion of Latinos, other non-African American minorities, and parents of at-risk children targeted by the Initiative, is viewed by some as the cause of their struggle with representativeness. In Houston, concerns are related to the perceived over representation of providers on the Board. Representation challenges of Boards which started from scratch, such as Richmond and Miami, are linked to the need to broaden the existing resident representation on the Board.

Linkages
The main finding with regard to the linkages that the different levels of the Initiative have established among themselves is that sites appear to rely on a combination of direct and indirect links. Direct links are characterized by the state, local, provider and neighborhood levels communicating directly with each other in dyads (e.g., state-to-local, state-to-neighborhood, local-to-neighborhood, etc.). The data suggest that this situation has led to the third party feeling excluded from the communication loop. A variation of direct links is the inclusion of state and local level representatives on the Board, as in the case of Boston and Miami. Indirect links refer to the use of intermediate channels of communication. This could be staff persons such as the State Coordinators and Project Director/Managers in Boston and Richmond, or an organization such as the Casey Policy Council in Houston, or the Children's Service Council in Miami.

Of particular interest is the response elicited by the participation of providers in this Initiative. Except for the Houston Board which drew its original membership from a group of provider organizations, the other sites appear to have mixed feelings about any links with providers. These feelings are attributed by some to a fear that the Initiative would become provider-driven rather than neighborhood-driven.

Return to Top

Closing Remarks

The Developmental Framework for neighborhood governance is a significant first step toward describing the mechanisms and events that lead to effective community participation within the context of systems reform. The framework's delineation of a tentative path toward neighborhood governance should provide a sounding board against which to challenge the proposed course and generate new ones. It is hoped that the repeated application of this framework to data generated during the remaining years of the neighborhood governance study will further the understanding of the complex process designed for this intervention.

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Return to Top

[Home] [Search] [Index]

Appendix

Return to Article

Community Information

September 16, 1994	1	3	5	7	9
Gathering and Securing Information	NGB pays no attention to gathering and securing information.	Information is collected but in an unsystematic, passive manner. Information is wholly provided by external sources.	NGB has limited involvement with local MIS development	NGB increases its involvement in the tracking of local programs through the local MIS	Information is collected in a systematic, pro-active fashion. There is a mixture of externally and self-generated data sources. Local MIS fully operational
Content	There is little or no information from or about the community gathered by the NGB	Information gathered is based strictly on the community's weaknesses and needs.			NGB seeks a blend of need- and strength-related information about the community.
Information Utilization Neighborhood Level	The NGB has no understanding of how to use neighborhood-related information.	Some indicators of overall neighborhood conditions are available, however, NGB decisions are still made based on opinion or group consensus.	Demographic and key indicator information begin to be considered in the decision-making process of the Board.		Information is routinely used to supplement the programmatic decision-making process and to monitor and improve neighborhood conditions

Consciousness/Knowledge

September 16, 1994	1	3	5	7	9
Belief in capacity to change	Participants and residents are fatalistic and feel isolated. There is no sense of trust among the various parties. History and tradition govern present relationships.	There is a sense of diminished isolation. NGB and residents remain pessimistic as to their capacity to change the system.	There is a developing sense of partnership among previously isolated groups. There is a willingness to break with tradition, where necessary. There is an increased sense of empowerment		Participants trust one another. There is optimism and a willingness to focus on the future, rather than the past. There is a perceived balance of power among all levels.
Overall Vision of the Initiative	No sense of vision. The process is dominated by the personal agendas of the participants.	There are several competing visions of the Initiative, often imposed on the community from external sources.	There are the beginnings of an internally-developed vision, shared by all participants.	Participants share a common vision. However, the vision has a limited, neighborhood focus.	There is a shared vision which is consonant with the Initiative's goals and goes beyond the neighborhood to the reform of the overall system.
Knowledge of Human Service Systems	No knowledge of public and/or private service systems. There is no transfer of knowledge among participants.	Parts of the system become distinguishable and recognizable to non-service providers.	There is some superficial knowledge of agencies and their functions. Knowledge is shared unsystematically.	Knowledge of agencies is more detailed and NGB members have regular opportunities to interact and learn from system providers.	Participants fully understand all levels of human service systems involved in the Initiative and their interrelations.
Awareness of Political Process	There is no awareness of the political processes linking state, local, and neighborhood levels. There is no awareness of key individuals and gate-keepers at any level	Participants can recognize key individuals and organizations.	Some key players roles and functions can be identified. Some linkages between levels become apparent		Participants understand the roles and functions of the key players. They have a thorough understanding of organizational interrelations and linkages, past and present

Return to Article

[Home] [Search] [Index]

Return to Article

Community Involvement

September 21, 1994	1	3	5	7	9
Outreach	No efforts are made to involve the community at large in any aspect of the Initiative, or to expand Board membership.	Efforts are made to recruit new Board members from the community. There is a recognition of the need to include culturally diverse populations but no resources are allocated to recruitment.	Long-term plans are made to recruit new members and volunteers at regular intervals. Resources and labor are allocated to improve outreach to culturally diverse populations.		The NCB regularly engages new members for participation on the Board, subcommittees, and/or any other NCB-sponsored activities. There is a large pool of involved residents who can fill positions as needed and supplement the work of the Board.
Board Representativeness	The composition of the Board is dictated by availability of volunteer residents to serve, rather than by using pre-established selection criteria. There is no clear picture of demographic characteristics of the community or the Initiative's target group. A small, nonrepresentative elite, which is not accountable to the community at large, dominates the NCB	There is a growing awareness of the need to ensure representation or involvement in the mental health system, etc.	The Board has a clear picture of the composition of the neighborhood and the target groups affected by the Initiative. The NCB is using an appointment system based on those characteristics. There is still a lack of accountability.		Residents feel well-represented by the Board and feel that they have a fair opportunity to participate in the selection of new members when needed. Board members are fully accountable to the community.
Communication	The NCB makes no effort to communicate with the community.	There is irregular, one-way communication from the Board to specific groups in the community (e.g., neighborhood associations, volunteer and civic groups)	The NCB is communicating on a regular basis with selected groups, and is attempting to include the community at large. Residents have limited opportunities to address the Board. Community access to Board meetings in terms of time, location, and special arrangements is limited.	Multiple methods are employed to encourage two-way communication with the community at large. NCB meetings are well-announced. Efforts are made to improve accessibility to meetings.	There is regular two-way communication channels between the Board and residents. There is a consistent, well-known time and accessible location for all meetings. There are special arrangements made to ensure access for all residents interested in participating.

[Home] [Search] [Index]

Return to Article

Linkages

September 16, 1994	1	3	5	7	9
State	There are limited links between the state level, and the NGB, local and provider levels	Communications are predominantly one-way, from the state to the NGB and other levels involved in the Initiative. The state offers a limited array of services and support to the NGB. Meetings are difficult to schedule and are held at the convenience of the state agencies	There is an increasing amount of two-way communication between the state, and the NGB, local and provider levels. The state offers a wide range of information and assistance. The NGB has several regular contacts in at this level	There is actual two-way communication. The NGB and the state government communicate freely in scheduled meetings. The state offers their full array of services to the NGB. The NGB has several liaisons at the state level	The NGB has many liaisons at this level. State agencies provide information and support the NGB decisions. The state government is easy to access and is quick to respond to NGB requests
Local	There are limited links between the local level, and the NGB, state and provider levels	Communications are predominantly one-way, from the local level to the NGB and other parties involved in the Initiative. Local governmental agencies offer a limited array of services and support to the NGB. Meetings are difficult to schedule and are held at the convenience of local agencies. The NGB has few, if any contacts within local governmental agencies	There is an increasing amount of two-way communication between the local level, and the NGB, state and provider levels. Local governmental agencies offer a wider array of information and assistance. The NGB has several regular contacts in at this level	There is two-way communication between parties. The NGB and the local level communicate freely in scheduled meetings. Local governmental agencies offer their full array of services to the NGB. The NGB has several liaisons within local governmental agencies	The NGB has many liaisons at this level. Local government agencies are easy to access, and are quick to respond to NGB requests
Providers	There are limited or no links between the service providers and the NGB, state and local levels	Communications are predominantly one-way, from the service providers to the NGB and other parties involved in the Initiative. Providers offer a limited array of services to the NGB. Meetings are difficult to schedule and are held at the convenience of the providers. The NGB has few, if any contacts in the agencies that affect the neighborhood.	There is an increasing amount of two-way communication between the providers, and the NGB, state and local levels. Service providers offer a wider array of information and assistance. The NGB has several regular contacts in the agencies	There is two-way communication between parties. The NGB and the service providers communicate freely in scheduled meetings. The service providers offer their full array of services to the NGB. The NGB has several liaisons within provider agencies	The NGB has many regular and liaisons with the various providers that affect the neighborhood. Providers offer information and support for NGB decisions. Agencies are easy to access and are available as needed.

Return to Article

[Home] [Search] [Index]

Return to Article

Organization

September 16, 1994	1	3	5	7	9
Role of NGB	There is no clear notion of the NGB's role in relation to state and local levels. Identity of the Board highly depends on the personalities involved.	NGB begins to define its role through relations between Board committees and the state and local levels. Individual personalities are still associated with the Board's identity	The Board formally operationalizes its mission and role in relation to the other levels involved. The Board begins to develop an image of its own independent of individuals. Role boundaries still become confused in some instances.	The roles previously outlined are implemented by all participants most of the time.	The role of the NGB in relation to state, local and provider levels, is clear to all members. The Board's identity is independent of the personalities of its members.
Structure	There may be pre-NGB steering and/or planning groups. Newly developed NGB has little structure and no permanent officers. There may be no by-laws, no regular meeting times or locations, and no committees.	Executive Committee positions are filled. The committee structure begins to emerge with the assignment of specific responsibilities, among which is the creation of by-laws. Meetings are held as needed.	The NGB now has a formal set of by-laws and procedures, but they are not always observed. Committee structure is present but unstable. Meetings are held regularly.	By-laws are adjusted based on the increased, practical experience of the Board.	There is a flexible and functional set of by-laws. There is an efficient and stable committee structure.
Roles of Officers and Members of the Board	There are no defined roles.	Leadership structure begins to emerge but there are no clear responsibilities associated with the officer positions. Members assume roles as needed.	Officers understand their roles but still suffer from a lack of acknowledgement by the rest of the Board or outside players. The Board defines basic roles and skill-requirements associated with them.	Leadership is acknowledged by most Initiative participants. Members are assigned roles based on experience and qualifications.	Leadership is recognized within and outside the Initiative. Officers and members have a thorough understanding of individual responsibilities.
Distribution of Labor	A small group of community members performs the bulk of the duties on the Board. Most members perform several duties at a time.	Board growth allows the members to spread responsibilities. However, working groups and committees are still made up of combinations of the same group of individuals. There is little or no choice when it comes to assignments.	Even though new members are available to perform specific duties, original Board members are reluctant to delegate duties to newcomers and participants without official Board membership.	The number of duties performed by individual Board members is reduced and responsibilities are shared. Willingness to delegate tasks improves. There is more variety in the composition of working groups and committees, and members have more choices.	Tasks are routinely delegated. The size of the Board now allows the members to team up to perform duties outside those of elected office. Member overlap between committees is minimal. Members can choose the group with which they would like to work.

Return to Article

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Organization Continued

	1	3	5	7	9
Turnover	There is a high degree of turnover due to burnout and overwork related to smallness of the Board, disenchantment and frustration, and lack of replacement opportunities. Departures from the Board are abrupt and unpredictable.	The Board recognizes the problems caused by uncontrolled turnover, but still lacks the mechanisms to address the issue. Vacancies take a long time to fill. Little or no term overlap. Many officers do not complete their term	Board's bylaws stipulate mechanisms to regulate turnover of members, and they begin to be implemented. The Board attempts to reduce the length of time it takes to fill vacancies. Departures from the Board are less abrupt	Unpredictable turnover is reduced to a minimum. Most departures from the Board are announced with enough time to allow for term overlap. Vacancies still take time to fill, but procedures are well understood and followed.	Replacements on the Board are made smoothly and promptly. Turnover is mostly due to completion of term rather than burnout or disenchantment. There is adequate term overlap
Training	There is no Board development training.	The Board periodically receives training in response to specific problem areas which are mostly identified by outsiders	The Board becomes more proactive in seeking training, but is not yet fully defining the training agenda. Training emphasis is still on "problems".	Topics of Board training are more diversified and less "problem" oriented. The Board's involvement in the development of a training agenda increases.	There is a long-term plan for Board development training. Training occurs at pre-established intervals. The Board is proactive in defining its own training needs and setting the training agenda

Programmatic Involvement

September 16, 1994	1	3	5	7	9
Program Development	The NCB has no long-term plan for program development. No programmatic information available to the Board. The NCB has no understanding of programmatic cause-and-effect relationships.	Programmatic decisions are based on provider/agency opinions or the personal preferences of NCB members. Programmatic information is available to the Board, but there is no understanding of how individual programs relate to each other. There is a focus on short-term benefits, and categorical programs.	The Board develops an awareness of the importance of programmatic interrelatedness. The opinions of the providers still dominate programmatic discussions, but the Board begins to emphasize comprehensiveness. Long-term outcomes begin to be addressed.	A strategic plan is under development. Providers negotiate program design with the NCB. The focus expands beyond short-term benefits to include overall client and community outcomes. Programs become less categorical, more integrated.	There is a strategic plan for program development in place. Programmatic decisions are now based on a clear understanding of cause-and-effect and programmatic interrelatedness. The focus is on long- and short-term outcomes. Information is used to evaluate and improve programs. Providers adapt their programs to fit the overall plan.
Collaboration and Coordination	The NCB has no concept of a multi-agency approach. There is no understanding of the collaboration mechanisms already operating in the community.	The NCB begins to develop links with existing interagency coordinating networks.	NCB encourages collaboration agreements.		NCB actively facilitates collaboration among providers. Keeps providers focused on the goals established in the comprehensive plan.

Return to Article

[Home] [Search] [Index]

Return to Article

Resource Management Capacity

September 22, 1994	1	3	5	7	9
Control over External Resources	The state or the grantee has total control over the allocation of resources, and decides how and when to disburse funds to the NCB	A limited amount of funds is transferred from the state to the local level. The NCB can access resources through specific requests to the local and state levels. Procurement of resources is done through state and local channels and are often slowed down by governmental bureaucracy. No attempts are made to expand the resource base beyond the Initiative.	A limited amount of discretionary funds is made available for the NCB to access directly and cover small goods and services expenditures. The remainder of the funds are still under state and/or local control. The NCB expands its resource base through internally planned activities.	Large amounts of funds are placed under the direct control of the Board. Bureaucratic restrictions to access funds decrease. The Board can access some goods and services directly.	The NCB has direct control over Initiative's funds. Bureaucratic barriers are minimal. The Board can access all goods and services directly. The NCB has developed an ability to use available resources in creative ways. The Board uses a combination of Initiative- and self-generated resources.
Management of Internal Resources	The NCB has no financial expertise in the managing and keeping track of funds available through the Initiative. The budget used by the NCB is the one developed for the Implementation application.	Efforts are made to track what the funds are available. There is an external fiscal agent performing accounting functions for the NCB. The Board begins to amend the budget as needs arise.	There is an accounting system for the resources made available to the NCB. Goods and services are paid for as soon as possible. The NCB writes its own budget, but is still reliant on an external fiscal agent.	The budget is finalized and approved. The NCB becomes its own fiscal agent. Goods and services are paid for promptly.	There is a system of internal checks and balances installed, including a system of audits. The budget is revised as necessary. The Board operates without deficit.
Allocation of Resources	Resources are distributed in an arbitrary manner. Personal agendas influence allocation decisions.	Resources are allocated to satisfy the most immediate needs.	An allocation plan is under development. Short-term goals still predominate.	Resources are allocated to satisfy long-term needs. Allocation of resources is related to and supportive of a service plan.	Resources raised by the success of the Initiative may be reallocated to the community to support programs.

Return to Article

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health, Institute, University of South Florida, 1996

Promoting Evaluation of Systems of Care: Stakeholder Needs and Technical Assistance Strategies

Authors
Introduction Methods Results Conclusions
Return to Table of Contents

Introduction

With the fundamental reconceptualization of mental health care for children and their families (Knitzer, 1993), and accelerating changes in service financing and delivery, there is increasing need for accountability and greater understanding of the impact of these systems changes (Saxe, Richmond, Gardner & Cross, 1994). Public sector agencies responsible for mental health services for children are facing increased expectations for evaluation, but often lack the resources, tools and experience.

This paper summary describes a needs assessment conducted by the Technical Assistance (TA Center) for the Evaluation of Children's Mental Health Systems that was designed to provide information about the evaluation interests and technical assistance needs of three key stakeholder groups. The TA Center works with state and local communities to enhance their capacity to conduct and utilize evaluation of children's mental health system changes. The results of the needs assessment and a pilot site have guided the TA Center's approach to technical assistance strategies and activities.

Return to Top

Method

Three stakeholder groups were included: (1) family members of children with serious emotional disorders, (2) state administrators of children's mental health programs, and (3) members of state legislatures and their staff. Information was gathered between April and September 1994.
Family members contributed information through a focus group conducted at the conference held by the Research and Training Center on Family Support and Children's Mental Health in Portland, OR in April 1994. Nine parents, identified through family support/advocacy organizations in their states, participated. The purpose of the focus group was to elicit from parents the crucial questions they have about service effectiveness and esponsiveness. Participants were also asked about how technical assistance might be used to increase families' involvement in evaluation.

Twenty-three state government children's mental health administrators were interviewed between May and September 1994. The sample was drawn from the membership of the State Mental Health Representatives for Children and Youth (SMHRCY). Interviews were semi-structured, took between 45 and 75 minutes to complete, and included queries about system changes, evaluation experience and resources, and technical assistance needs related to evaluation.
State legislators were assembled for a focus group designed to explore their needs for information. The forum, held in Washington, DC in June 1994, was attended by ten legislators, legislative staff members and other key policy and decision makers. The group addressed several questions, including: what information is needed by legislators, at what points in time; what information gaps exist; and in what format is information most useful?

The TA Center provided on-site technical assistance at a community service program, which, in addition to providing immediate help, was designed to elicit additional information about the specific needs of customers, the most useful approaches to providing technical assistance, and the amount of time and follow-up required.

Return to Top

Results

Family Members

Information from family members shows that their knowledge of and involvement with evaluation activities varied markedly. Family involvement was typically related to satisfaction surveys or monitoring for federal block grant requirements. One major barrier to family involvement was lack of knowledge about evaluation in general, and absence of information about specific evaluations in their states or communities.

Families hoped for evaluations in the areas of cultural responsiveness of services, service fit (in addition to consumer/family satisfaction), and tracking to assess whether those seeking services actually receive them. When they are involved at the design stage, families believe they can make important contributions clarifying the meaning of inquiries and the language used. Families reported that they need concrete examples of the role and importance of program and systems evaluation.

Administrators of State Child Mental Health Programs

All states were experiencing one or more major systems change, generally in multiple domains simultaneously. The developmental stage of changes varied markedly within and among states. Evaluation of systems change had been limited in all but a few states in the sample. The most common evaluation activities had been surveys of consumer/family satisfaction and level of involvement. Administrators reported that they desire evaluation to understand the progress, impact and effectiveness of changes as they are implemented in their states.

However, while public children's mental health agencies have the responsibility to conduct evaluations, they need more technical expertise and resources to carry this out in a meaningful way. Although many states had in-house evaluation capacity, university affiliations, or both, such resources were often adult-oriented and of limited use for children's mental health systems evaluations. Primary areas of need for technical assistance for this group of stakeholders are illustrated in Table 1.

Legislators

A number of key issues were identified by legislators participating in the focus group. They believed that too little is known about program outcomes; the crucial question "How does this service effect someone's life?" is answered too rarely. Legislators were also aware that basic data are often not available or not accurate. They acknowledged that even data about who is being served in which programs frequently are inconsistent or incomplete.

Legislators wanted to know the individual successes or unhappy stories associated with services. They suggested that this information helps them understand programs better and helps them interpret information to their colleagues. They also wanted to know if a service is cost effective. A multiple system perspective is important to legislators because they must make decisions related to a number of child-serving agencies all of which have an impact on the others. They indicated that information about how changes in one systems effects other systems is helpful.

Legislators reported a need for information at critical points in the legislative decision-making cycle. They need information that is concise and that is customized for the issue or discussion at hand.

Community Site

Our understanding of technical assistance needs was furthered through a pilot intervention with Project Connect, a local program in the Metro South Region of Massachusetts. This program integrates the efforts of agencies and families to develop and implement treatment plans for children with emotional disturbances. Through providing consultation on Project Connect's evaluation, as well as reviewing documents and interviewing staff, we learned more about the technical assistance needs of an evaluation in process.

1. Time pressures. Needing data quickly for program improvement and funding agency requirements, Project Connect rapidly conducted an initial evaluation using focus groups and satisfaction surveys with parents, service providers, and referring professionals. We learned that longer-term planning for evaluation must be built around the need for quick turnaround on data.
2. Limited resources for evaluation. Project Connect's limited resources made even modest evaluation difficult to implement. In addition to TA Center help, Project Connect recruited community volunteers to administer the surveys and graduate students to analyze data. We learned that agencies may need assistance to develop resources for basic evaluation functions.
3. Small increments. Project Connect's modest efforts demonstrated the value of developing evaluation in small increments. The scope was feasible and widely acceptable, and the results were still useful. Family feedback, for example, which suggested overall satisfaction with the program, led to program improvements (e.g., more involvement of extended family members), and stimulated thinking about what child and family outcomes were reasonable to expect. This success encouraged additional evaluation efforts. We learned to support small improvements in evaluation that take into account the time pressures and resource limitations faced by children's mental health systems and program.

Return to Top

Implications

All representatives of stakeholder groups reported that they want data and outcome information to inform policy decisions and program development. They suggested that the most useful data are timely, concise, and presented in user-friendly language. They agreed that evaluation findings should be disseminated among policy and decision makers, service providers, consumers and families as part of a continuous feedback loop. Evaluation information can then be used to improve or change programs, make funding decisions, and advocate for new services.

Stakeholders also share a concern about selecting and measuring outcomes. States need assistance to determine which outcomes are appropriate for a state/community, select outcome measures, and gather the necessary data. Results of focus groups indicated that outcome information is desired across a number of domains, including child and family functioning, consumer/family satisfaction, service fit, cost effectiveness, and cross-system collaboration. Many stakeholders were concerned that existing instruments are too narrow and too deficit-based.

There was agreement that children's mental health data are problematic. Data that do exist are embedded in the records of categorical agencies and do not give a holistic picture of the child and family. Computerized data systems need to be strengthened, both within mental health agencies and across agencies.

Family-professional collaboration in evaluation has not been explored fully. We feel that, as key stakeholders, families must be brought more fully into the evaluation process at all points. Family members could benefit from information and training about how evaluation can be useful to them and how to become meaningful partners with other stakeholders around evaluation. Another issue that is central to the philosophy of systems of care is cultural competence, yet assessment of cultural competence in children's mental health is at a nascent developmental stage. The TA Center promotes evaluation as a collaborative effort, encouraging key stakeholder groups to participate in a range of evaluation activities. We believe that evaluations that are fully participatory will reflect and respect the participants' cultural, social, and ethnic backgrounds.

Findings from the needs assessment demon-strate the importance of providing a range of technical assistance activities that both demystify and promote evaluation to all stakeholders in children's mental health. The TA Center is fostering the use of evaluation to produce useful and timely information that will constructively inform and improve systems change. In many places the most useful evaluations may be those that will provide information about collaboration and other structural changes, about consumer/family needs and satisfaction, and about intermediate, not long-term, child and family outcomes. Many states will need technical assistance to help them conduct evaluation in small, incremental steps, while developing a more comprehensive, long-term plan.

Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

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The Comprehensive Services Act: First Year Implementation Assessment

Authors
Introduction Method Results Discussion
Return to Table of Contents

Introduction

On July 1, 1993, Virginia implemented a major reorganization of services for youths with serious emotional and behavioral problems. Through the Comprehensive Services Act (CSA) for At-Risk Youth and Families, a system of services was to be created that was "child centered, family focused and community based." The CSA requires local interagency teams to plan and manage services and consolidated eight categorical funding streams to fund services. The new system of services is intended to:

- increase interagency collaboration and family participation in service delivery and management;
- dentify and intervene early with young children at risk and their families;
- encourage public-private partnerships;
- provide communities flexibility in the use of funds; and
- reduce the use of more restrictive services, including out-of-home placements.

A five-year evaluation plan was developed to be implemented in two stages. During the first stage, beginning July 1, 1993, the focus was on assessing the implementation of the CSA. During this stage of the study, the questions related to program implementation and interagency collaboration and funding were emphasized. Beginning June 1995, the research components related to assessing the impact of the projects on individual youths and families will be implemented.

The focus of this report is on the implementation of the CSA in fiscal year 1994.

Study Goal and Evaluation Questions
The goal of this study was to examine those evaluation issues which were related to the implementation of the CSA. These issues included:

Youths Served &shyp;The number and characteristics of the youths being served through the family assessment and planning teams (FAPTs) and/or receiving pool-funded services.

Team Functioning and Interagency Collaboration&shyp;The composition, coordination and collaboration of community planning and management teams (CPMTs) and family assessment and planning teams (FAPTs).

Family Participation&shyp;The involvement of family representatives and family members in the CSA process.

Public-Private Partnership&shyp;What is the experience during the first year of closer working relationships between public and private agency staff?

Goal Achievement&shyp;CSA participants' opinions on progress made toward reaching the goals of the CSA.

Return to Top

Results and Implications

Youths Served

About 8,000 young people in Virginia were served through CSA pool funds during the first year. A majority (approximately 60%) of CSA youths were White, male and between the ages of 13 and 17. Most (91%) of the youths were "mandated," meaning they were entitled to services through federal and/or state mandates.

Of all CSA youth served the first year who were mandated, 57% were in private, residential care. About 66% of all youth served through CSA pooled funds were placed outside their homes. These figures include all foster care children. About 83% of all youth received services provided by the private sector. This figure, too, includes all foster care children. Six percent of mandated youth received non-residential, public services.

Team Functioning/Interagency Collaboration

A statewide survey mailed in April 1994 to members of all CPMTs and a sample of FAPTs addressed issues related to team processes and development. About 1,100 surveys were distributed statewide. There were 450 CPMT respondents and 89 FAPT respondents to the survey.

Information gathered from CPMT chairpersons revealed that there had been positive collaborative relationships between their teams and the local school system, local government, and local judges, though there is room for improvement in the latter case.

In addition, FAPT members were more likely than CPMT representatives to report that their team functioned cohesively, with a common purpose. Moreover, FAPT respondents agreed at a lower rate than their CPMT counterparts that they had a sufficient number of CSA training opportunities, and that they had adequate opportunities to learn about other agencies represented on their teams.

A special study was designed to explore interagency collaboration among the five agencies participating on the CPMTs. Findings of this research suggest that local agencies had already set the stage for effective collaboration prior to the inauguration of a "comprehensive" approach to services. One area that seemed to need attention&shyp;and apparently received it during the first year&shyp;was the level of agreement among agencies regarding the needs of at-risk youth and families, and the services necessary to meet these needs.

Two key factors in the study were predictors of success in collaborative efforts. One was "respon-sibility"&shyp;the degree to which agency represent-atives believed that each collaborating agency carried out its responsibilities and commitments to other agencies. The other factor was "satisfaction"&shyp;the overall level of satisfaction members had with the other public agencies represented on their CPMTs.

All five agencies received high ratings on responsibility from at least 60% of their peers. Likewise, all agencies received high ratings on satisfaction from at least 56% of their peers. These findings and others point to an enhancement of interagency collaboration through the CSA team processes. Moreover, it is likely that agencies will engage in future collaborative efforts to address the needs of troubled youth and their families in Virginia.

Family Participation

FAPT and CPMT members were surveyed about parent representatives on their teams. Responses were generally positive.

- 87% of CPMT respondents and 82% of FAPT respondents agreed that meetings were scheduled at times parents could attend.
- 79% of CPMT respondents and 88% of FAPT respondents agreed that parent representatives participated in team decision-making.
- 74% of CPMT respondents and 78% of FAPT respondents agreed that parent representatives had a good understanding of the problems of at-risk children and youth and their families.
- 65% of FAPT respondents agreed that participation of the parent representatives on FAPTs had resulted in improved service plans for at-risk youth and their families.
- 59% agreed that services have improved with parent participation.
- FAPT members were asked a set of questions about participation in the CSA process by parents of the youth served. Their responses were also generally positive.
- 79% reported that parents attended FAPT meetings at which their children were discussed.
- 82% said that the parents actively participated in these meetings.
- 94% agreed that the presence of family members at FAPT meetings helped to ensure that the views of the youth's family were adequately represented.

Public-Private Partnership

CPMT survey respondents provided the following information about their perceptions of privately provided services.

- 65% of CPMT respondents reported that privately provided services were available for local clients.
- 64% said the availability of private services had not increased since the implementation of the CSA on July 1, 1993.
- 70% thought that privately provided services were of "high quality."
- 75% agreed that private agencies "demonstrated considerable knowledge" of the service needs of at-risk youth and their families.

Finally, CPMT chairpersons were asked their perceptions of fees charged by private providers. Of the 53 chairpersons who indicated having knowledge of private provider rates, 28 (53%) perceived an increase in fees since the beginning of the CSA.

A majority of all survey respondents saw no increase in private services during the first year of the CSA. Such a change in the availability of services could not be expected to happen quickly, nor would it happen automatically, especially in areas which had no history in, nor infrastructure for providing adequate services to children. Nevertheless, the founders of the CSA hoped that private providers, working closely with public agency staff and parent representatives, would increase their services, especially those that were community-based.

Goal Achievement

Among the seven major CSA goals, the one which received the most recognition of progress by both CPMT and FAPT survey respondents was interagency collaboration. There was also considerable acknowledgment of progress made in incorporating families into the service planning processes of the CSA.
A majority of respondents perceived at least some or moderate progress toward the achievement of three goals:

- provide communities flexibility in the use of funds;
- provide services in the least restrictive environment;
- improve the quality of services to troubled youths and their families.

The two goals for which all respondents reported the least amount of progress achieved were public-private partnerships and early identification of, and intervention with, at-risk young children. It is understandable that more than 9-12 months would be needed to make substantial progress in these areas. In fact, it was surprising to observe the overall amount of goal achievement perceived by CSA participants during its first year of operation.
Return to Top

Conclusion

In summary, survey respondents feel that the CSA has significantly changed the way in which Virginia addresses the emotional and behavioral problems of its young people. This report examined the successes and shortcomings of the CSA's first year of implementation. The focus was on the perceptions of those most directly responsible for the day-to-day operations of the CSA. The information they provided indicated that a tremendous amount of individual and group effort was expended to inaugurate the CSA. These efforts, moreover, led to significant accomplishments in a short period of time. Most notably, a high level of collaboration among agencies existed throughout most of the state. Through the CSA process, agency staff coordinated their efforts to deal with at-risk youths and their families. Moreover, survey respondents indicated that parents, both as community representatives and as guardians of troubled youth, have been meaningfully included in the process.
Return to Top

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Return to Top

[Home] [Search] [Index]

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Access Vermont: A Statewide Evaluation of Non-categorical Service Delivery to Children and Families&shyp;Meeting Community Needs, Measuring Outcomes

Authors

Introduction Methods Discussion References
Return to Table of Contents

Introduction

Access Vermont is part of the Comprehensive Community Mental Health Services Program for Children, a national services initiative funded through the Center for Mental Health Services (CMHS) under the Family Preservation Act to provide children's non-categorical mental health services in 22 sites across the country. The grant will last for 5 years and began in October, 1993. Vermont is one of two states to receive statewide funding through this initiative. This paper will provide an overview of Access Vermont implementation and the evaluation component of Access Vermont with particular emphasis on:

1. the creation and implementation of an evaluation process that is individualized and which is beneficial to each local community;
2. helping communities to incorporate evaluation into service provision;
3. helping communities to empower children and families; and
4. approaches to measuring outcomes of community-based, non-categorical services.

Access Vermont: Implementation

Background of Non-categorical Services in Vermont

Over the past decade, Vermont has made considerable progress in developing a statewide, community based system of care for children and adolescents experiencing severe emotional and behavioral disturbances and their families. On the individual services level, Vermont developed a statewide capacity to provide community-based wraparound services with funding from Robert Wood Johnson (RWJ). On the systems level, funding from CASSP allowed each of the twelve local areas in Vermont to establish Local Interagency Teams (LITs) made up of parents, community members, and local agency representatives.

Access Vermont has built upon these systems of care established under RWJ to help provide community-based, locally planned and implemented, non-categorical services. Through these systems of care, Vermont has been able to reduce the rates of out-of-school-district, out-of-home and out-of-state placements of children and youth, as well as the numbers of children taken into state custody (Vermont Department of Mental Health and Mental Retardation, 1993).

Through the implementation of innovative programs and interagency teams, Vermont's mental health service system has been effective in serving many of the state's most challenging children and youth in their homes and communities, rather than in more restrictive treatment settings.

Long Term Goals of Access Vermont

The long term goals of Access Vermont are to continue to reduce the rates at which Vermont's children are being removed from homes, schools and communities to more restrictive treatment settings, and to demonstrate better outcomes and reduce costs in the process. These goals will be accomplished through:

1. increasing the quality of services available for children and families in home and school settings, with particular emphasis on effective and timely crisis response;
2. evaluating and feeding back consumers' responses about their satisfaction with services and their empowerment within the system; and
3. effectively building evaluation, with an eye towards outcomes, into service provision.

Return to Top

Access Vermont: Evaluation

Development

While the Local Interagency Teams have served primarily as case review teams in the past, the LITs are now moving towards policy making, by taking primary responsibility for local interagency planning, coordination and services integration. Through the LITs, community based services have been designed by local areas to meet their individual needs and to build on existing strengths. At this writing, 11 of the 12 proposals for services have been reviewed and approved by the Vermont Department of Mental Health. Each catchment area receives money to implement these Local Priority service plans. These individualized services, inspired by community needs, are the heart of Access Vermont.

Services that are being implemented under Access Vermont by local areas include crisis outreach and stabilization, crisis hotlines, short-term residential crisis stabilization programs, family crisis response teams, respite care, day treatment programs (school-based programs, after school and summer programs, day programs for transition aged youth), detoxification facilities, transition services, and a family support center (see Figure 1).

Evaluation

With all the different, individualized services being implemented and offered under Access Vermont, evaluation can be a challenge. Therefore, evaluation is being conducted on two levels&shyp;the individual level of the child and family, and the systems level of the service providers.

Consumer Evaluation

A vital part of Access Vermont is helping communities to empower children and families, and helping communities to evaluate empowerment and satisfaction. Families will be asked about their empowerment and satisfaction with prior and current services through measures (Family Empowerment Scale, Koren, DeChillo & Friesen, 1992; Client and Youth Satisfaction Questionnaires) administered 2 weeks after the start of multi-agency services by members of the Evaluation Team (staff from the Vermont Department of Mental Health, the University of Vermont, and a Parent-Interviewer, hired through the Vermont Federation for Families).

Demographic information and a number of standardized measures (CBCL: Achenbach, 1991; Youth Self Report: Achenbach, 1991; Child and Adolescent Functional Assessment Scale: Hodges, 1994; and Residential Living Environments Scale: Hawkins, Almeida, Fabry & Reitz, 1992) will be completed at intake by service providers for all consumers receiving services under Access Vermont. Follow-up interviews, consisting of the empowerment, satisfaction, and standardized measures will be conducted by the Evaluation Team with a random sample of consumers at 6 months, 1, 2, and 3 years after Intake for those consumers still receiving services. Youth and parents will be reimbursed individually for their efforts in these follow-up contacts.

Addressing the Evaluation Needs of Local Areas

All of the measures listed above will be part of the evaluation at all 22 sites. However, the evaluation team is also working with each of the 12 local sites to evaluate any additional outcomes that the site may want to address.

For example, one predominantly rural area that is implementing crisis outreach services wants to reach previously unserved, rural populations, and to assess how many "saves" they accomplish&shyp;that is, how many children and youth they successfully prevent from crises that would have result in out-of-home placements. Their evaluation centers around these issues, as well as evaluation of prior service involvement to assess how many previously unserved consumers they are reaching.

Some areas will also be working closely with the schools to evaluate educational outcomes. The evaluation team is working with these areas to help them get the schools involved, and use outcome measures that will best serve their needs.

System Evaluation

Each LIT will serve as the hub connecting the local network of services used by children experiencing severe emotional disturbance. In order to evaluate how the different interagency systems are working together, LIT members will complete the Local Interagency Collaboration Checklist (Froelich, 1992) at the implementation of Access Vermont services, and annually thereafter for 3 years. Information obtained from this measure will be fed back to local areas.

Feedback

As both direct service providers and researchers know, service provision and evaluation have often been viewed as mutually exclusive and therefore conflicting interests. Evaluation outcomes are often not seen by service providers, and all too often, research findings are not applied to create positive organizational or service delivery changes. In the Access Vermont project, we are committed to a collaborative model where research, evaluation, and outcomes will blend with the innovative services that are being provided by local areas under this project, to maximize the benefits for both service providers and consumers.

One of the most important steps in this collaborative process is the creation of a feedback loop, where service providers will receive timely periodic feedback on service outcomes and empowerment measures. Feedback will include not only standardized measures, but specific outcomes that individual communities have identified as important.

We feel that one of the most effective ways to blend services and evaluation is to incorporate standardized assessment and outcome measures into intake procedures and clinical planning. By working collaboratively with service providers, assessment tools such as the CBCL can become beneficial in assessment procedures and ongoing clinical planning. A vital component of both local ownership and clinical relevance is helping service providers to utilize the standardized measures for assessment and treatment planning. The evaluation team will work to provide local areas with training in the clinical use of the assessment measures. We believe that empirical assessment measures will not only help to evaluate effective services, but can also aid in the provision of the most effective and relevant services.

Quarterly data reports will also be sent to local areas to give summary feedback on all measures for the consumers they have served. These reports will help service providers gain a broader picture of the children and families they are serving, the types and hours of services they are delivering, and the difficulties and challenges of the consumers they are serving. Data will also be fed back in customized reports, in ways that local areas and agencies have deemed most useful to them.

One exciting project the evaluation team has begun work on is the Access Vermont Newsletter, filled with items that are relevant to the project. We are encouraging LIT members, service providers, and anyone else involved with Access Vermont to contribute ideas or items to the newsletter. We are very excited about this project and hope that it will aid in feedback and communication between local areas and the evaluation team.

Return to Top

Conclusions

Evaluation of non-categorical mental health services for children and families as innovative and as diverse as those planned under Access Vermont is certainly a challenging task. The evaluation itself has several aspects; it must support non-categorical children's mental health services, empower families and communities, and provide meaningful outcome data. In keeping with the system of care philosophy of family and community empowerment, both the services and the evaluation of those services are being designed by a collaboration among families, communities, mental health systems, and experienced researchers.

It our belief that sharing our experiences in the design and implementation of this evaluation will be valuable, not only to the service systems and consumers of Vermont who are a part of Access, but to other communities, service providers and researchers who are implementing and/or evaluating similar services.

Return to Top

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Return to Top

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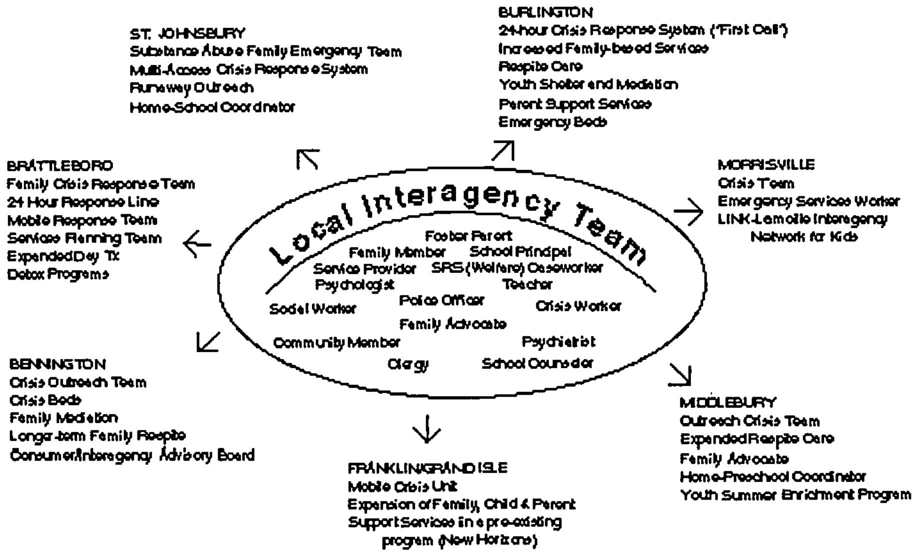
Return to Top

[Home] [Search] [Index]

Table 1

Return to Article

Figure 1
Designing Community-Based Services



Note: Each of the 12 Local Interagency Teams (LITs) worked to develop a plan for Access Vermont funds to meet the needs of their local area.

[Home] [Search] [Index]

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Conceptualization and Initial Development of the Ohio Scales

Authors

Introduction Results References
Return to Table of Contents

Introduction

The Southern Consortium for Children (SCC; a regional mental health authority) and local county administrations have gradually changed the mental health service delivery system in Southeastern Ohio from a state-operated hospital model to a community-based, community-directed model. Program development has centered around the creation of children's mental health case management, therapeutic foster care, home-based services, and other services critical to providing a regional system of care. However, little information regarding the impact or effectiveness of system changes is available. With the emphasis on evaluation (Stroul & Friedman, 1994; both in terms of rigorous methodologies and naturalistic studies of program effectiveness) along with recent health care reform and the push for consumer driven service delivery (Burchard & Shaefer, 1992) the SCC increasingly interested in developing methods of ongoing evaluation.

Conceptualization of Outcome

This paper represents the initial efforts of the SCC to develop a system for ongoing evaluation of clinical outcomes for youth receiving services in collaboration with Ohio University. To address region specific needs, four areas of outcome assessment were considered: (1) problems associated with rural service provision; (2) perspectives of various stakeholders; (3) current research methods of outcome measurement; and (4) a theoretical and conceptual scheme of outcome assessment.

Unique Problems in a Rural Setting

Southeastern Ohio presents several unique problems for the provision of services and the development of an evaluation program. The service area is composed of ten counties located in the foothills of the Appalachian Mountains and in the heart of Ohio's 29 designated Appalachian counties. The terrain is rough and marked with poor roads and a non-existent public transportation system. The region is characterized by a sparse population, economic underdevelopment, and a low tax base. Not only do these difficulties impact the provision of services, but they necessarily affect the implementation of any outcome evaluation program. Evaluating service effectiveness must rely on brief, inexpensive methods of assessment that have intuitive value for the consumer.

The Input of Stakeholders

Strupp and Hadley (1977) proposed a tripartite model of mental health outcomes in which three interested parties consider the outcome of mental health interventions: society, the client (or consumers), and the mental health professional. Based on the viewpoint of the stakeholder (Gold, 1983), different criteria are selected to measure successful treatment. An initial step in establishing an evaluation plan is to make inquiries into these populations with regard to what kind of outcomes they deem are important. We used a Social Validation Questionnaire (VanDenBerg, Beck, & Pierce, 1992) to provide input from a variety of viewpoints regarding outcome assessment in our region.

Return to Top

Research Input

Studies investigating the effectiveness of mental health services for children were also examined to aid the outcome development plan (e.g., Duchnowski, Johnson, Hall, Kutash, & Friedman, 1993). The review focused on instruments used to evaluate outcome and identified relevant domains of outcome. While all areas of assessment were not included, reviewing well-designed studies helped to ascertain the most important domains of assessment.

Use of a Theoretical and Conceptual Measurement Classification Scheme
Because of the divergent processes that occur during mental health intervention, divergent methods of measurement are used to capture the complexity of human functioning and change. Selecting from among these methods may be difficult if not guided by a theory. An ideal scheme may give purpose and direction to the selection of a final assessment package. The conceptual scheme used in this plan (Lambert, Ogles, & Masters, 1992) includes four theoretical dimensions upon which outcome instruments vary: (1) the content area addressed by the instrument, (2) the source of outcome ratings sampled by the instrument, (3) the outcome instrument's method or technology of data collection, (4) and the time orientation or stability of the instrument. The scheme was used to help select and develop an outcome assessment package that would tap a variety of content, source, technology, and stability dimensions.
Return to Top

Summary of Conceptualization

Based on theses considerations, a list of desirable characteristics for measuring clinical outcomes was developed:

1. Outcome assessment must be pragmatic in terms of time and expense. Many research-based instruments are too cumbersome for ongoing clinical use.
2. Outcome data must be understandable for paraprofessionals, parents and children.
3. Effective outcome assessment should include input from multiple sources.
4. Multiple content areas of outcome should be considered.
5. Pragmatics should be counterbalanced by psychometric properties, including: reliability, validity, and sensitivity to change.

Return to Top

Development and Initial Evaluation of the Ohio Scales

Based on our conceptualization, a set of brief, pragmatic outcome measures were developed. Three parallel forms of the Ohio Scales (OS) were developed for completion by the youth's parent or caretaker (OS-P), the youth (OS-Y), and the agency worker (OS-A). Four domains of outcome were selected: severity of problems, level of functioning, hopefulness, and satisfaction with treatment. Parents and youth rate all four areas. Case workers rate the youth using the problems and functioning scales.

To begin evaluating the psychometric properties of the instrument, two samples of data were collected. For the community sample, approximately 297 Jr. High and High School students (average age 14.36, SD 1.54) completed the OS-Y. In addition, 281 parents (average age 39.43, SD 7.36) of each respective youth completed the OS-P. For the clinical sample, case managers at two agencies rated a total of 78 youth (average age 14.28, SD 2.16). Additionally, 16 youths from this population completed the OS-Y and Youth Self Report (YSR; Achenbach & Edelbrock, 1983) and 28 parents completed the OS-P and

Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983). Table 1 provides basic descriptive statistics for the OS problems, hope, and functioning domains for each respective population.

Reliability

Internal consistency data for each OS category is presented in Table 2. The internal consistencies for each category are adequate. Additional projects are underway to assess the inter-rater and test-retest reliability of the Ohio Scales.

Validity

Evidence of the concurrent, discriminant, and construct validity of the OS was also collected. Parent and youth ratings of problem severity and functioning were correlated with the CBCL and YSR (see Table 3). The CBCL and YSR were included primarily to assess concurrent validity of problems. Additional studies are underway to validate the functioning scales. Case manager ratings of functioning and problems were correlated with the Progress Evaluation Scales (PES; Ihilevich & Glesser, 1979).

The community sample provides some evidence for the discriminant validity of the OS. Five t-tests were conducted using parent ratings of functioning as the dependent variable to examine differences between students who had repeated a grade, been arrested, received mental health services, been assigned to classes for students with behavioral problems, or assigned to classes for students with learning problems, and those who had not experienced these events. Students who had been assigned to classes for youth with learning difficulties, had received previous mental health services, or had been arrested had significantly poorer functioning and more severe problems than students who had not experienced these events. Students who had previously been assigned to classes for youth with behavior problems had poorer functioning (but not more severe problems) than students who had not been assigned to these classes.

The PES were administered in conjunction with the OS-A in the clinical sample on two separate occasions (approximately 4 months apart) to assess sensitivity to change. Change scores on the OS-A problems and functioning scales significantly correlated with the PES ($r = .54$, and $.56$, $P < .001$) and indicate a relatively high degree of agreement between the two instruments with regard to client change.

Return to Top

Conclusion

While by no means completed, the results of the initial investigation of the psychometric properties of the OS are quite positive. The Ohio Scales have adequate internal consistency and preliminary evidence of concurrent and construct validity along with sensitivity to change. Additional projects are underway to further examine these properties. By conforming to the rather stringent conceptual outcome requirements, the developers hope that the final result will be pragmatically useful yet methodologically rigorous outcome measures that can be used for practical, ongoing evaluation of services for children and youth.

Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

Table 1

Return to Article

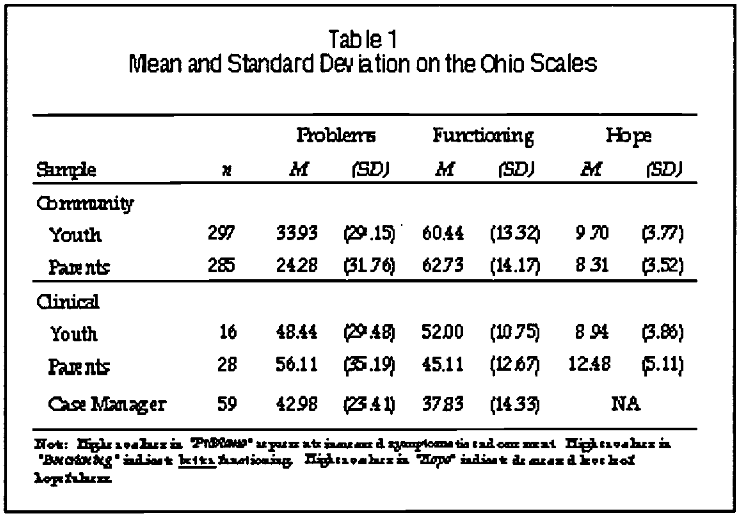

Table 1
Mean and Standard Deviation on the Ohio Scales

		Problems		Functioning		Hope	
Sample	*n*	*M*	*(SD)*	*M*	*(SD)*	*M*	*(SD)*
Community							
Youth	297	33.93	(29.15)	60.44	(13.32)	9.70	(3.77)
Parents	285	24.28	(31.76)	62.73	(14.17)	8.31	(3.52)
Clinical							
Youth	16	48.44	(29.48)	52.00	(10.75)	8.94	(3.86)
Parents	28	56.11	(35.19)	45.11	(12.67)	12.48	(5.11)
Case Manager	59	42.98	(23.41)	37.83	(14.33)	NA	

Note: Higher values in "Problems" represent increased [illegible]. Higher values in "Functioning" indicate better functioning. Higher values in "Hope" indicate decreased levels of hopefulness.

[Home] [Search] [Index]

Table 2

Return to Article

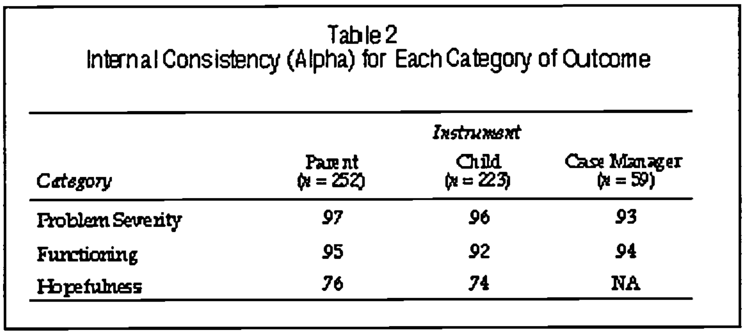

Table 2
Internal Consistency (Alpha) for Each Category of Outcome

	Instrument		
Category	Parent (*n* = 252)	Child (*n* = 223)	Case Manager (*n* = 59)
Problem Severity	97	96	93
Functioning	95	92	94
Hopefulness	76	74	NA

[Home] [Search] [Index]

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Impact of the Child and Adolescent Service System Program in California

Authors

Introduction Methods Results Conclusions
Return to Table of Contents

Introduction

The Child and Adolescent Service System Program (CASSP; Day & Roberts, 1991; Stroul & Friedman, 1986), which received initial federal funding in 1984, was established to assist states and communities in their efforts to improve child and adolescent service systems. CASSP has promoted the development of systems of care that are child-centered and family focused, with the needs of the child and family dictating the types and mix of services provided.

In 1988, when the California State Department of Mental Health (Cal-DMH) received federal funding to implement the system of care principles developed by CASSP, a system of care program in Ventura county had been successfully in place for several years and the positive effects on children's mental health services had been demonstrated (Feltman & Essex, 1989; Jordan & Hernandez, 1990). Also in 1988, California State Assembly Bill 377 (AB 377) had been passed to expand the Ventura program into three additional counties (Attkisson & Rosenblatt, 1993; Rosenblatt & Attkisson, 1993; Rosenblatt & Attkisson, 1992; Rosenblatt, Attkisson, & Fernandez, 1992; Ventura County Health Care Agency, 1989). Therefore, the federal CASSP grant was seen by Cal-DMH as an opportunity to support and expand local system of care efforts while attempting to accomplish similar reforms at the state level.

In 1993, an evaluation of the impact of CASSP on California's mental health service system for children and adolescents with serious emotional disturbance was conducted. Objectives included (1) evaluation of CASSP efforts to develop interagency and interdepartmental coordination and collaboration, (2) evaluation of CASSP efforts to develop family participation and advocacy related to services for children and adolescents with serious emotional disturbance (SED), and (3) evaluation of CASSP efforts to promulgate cultural competence in systems of care for children and adolescents. A comprehensive description of the procedures and results of this evaluation have been previously reported (Madsen, Dresser, Rosenblatt, & Attkisson, 1994); the current analysis will focus on the similarities and differences between informant groups (county human service agency staff and parents of children and adolescents with SED) in their reports of the impact of CASSP and the changes in California's service delivery system over the last four years.

Return to Top

Method

To accomplish the evaluation objectives, three studies were conducted: (1) face-to-face interviews with county level agency staff, (2) telephone interviews with members of a statewide parent organization, and (3) a comprehensive review of relevant federal, state, county, and local documents. Selected results of the first two studies will be presented here, while results of the third study are presented in a companion paper (Dresser, Clausen, Rosenblatt, & Attkisson, 1995).

Subjects

In the first study, of the 86 persons identified by state and county mental health staff as potential key informants in the selected 21 counties, interviews were conducted with 60 respondents (70%). Subjects for the second study were members of a statewide organization of parents and family members of children and adolescents with SED, the Family Network of California (FNC). Interviews were conducted with 67 respondents (31.5% of the identified sample) across 23 counties in California.

Measurement
A 45-minute, semi-structured interview was developed for use with management and program staff in county departments of mental health, social services, juvenile justice, and education. Respondents were asked to estimate the impact of California CASSP in several areas, as well as to rate the changes in county service systems, using a Likert-type scale of 5 items, ranging from 1 (none or no impact) to 5 (extensive impact). Informants were also asked to respond to several open-ended questions regarding changes in service systems for children and adolescents with SED over the last four years.

The face-to-face semi-structured county interview format became a model for development of a semi-structured 30-minute telephone interview for use with parents of children and adolescents with SED.

Return to Top

Results and Implications

Interagency Collaboration
When asked to rate the impact CASSP had on increasing interagency collaboration in the delivery of services to children and adolescents with SED, both agency staff and parent informants indicated, on average, that CASSP had some impact in this area; however, the parent sample appeared divided on this issue, with many rating CASSP's impact as significant (25%) and many others rating it as minimal (17%). All of the county interviewees responded yes when asked if agencies in their county were working together in important ways; however, only 60% of the parents interviewed responded yes to this question. Overall, interview results suggest there is a perception that collaboration between agencies providing human services to youth with SED increased modestly throughout the State of California during the four years of CASSP implementation.

Family Participation
When asked to rate CASSP's impact on parent involvement in service development, implementation, and evaluation, county informants indicated a greater impact (mean = 3.36 on a scale of 1 - 5) than did parent informants (mean = 2.93 on a scale of 1 - 5), with most people in both groups (68% of county informants and 58% of parents) indicating CASSP had some (> 3 or some on a scale of 1-5) impact in this area. As compared to four years earlier, 82% of county agency informants and 58% of parent informants felt that service providers were more aware and supportive of parents and families of youth with SED. Thus, although subject responses to open-ended questions demonstrated that families of youth with serious emotional disturbance perceive human service agencies as inaccessible and frustratingly complex, there is evidence that CASSP had an impact on increasing the involvement of parents in human service planning and delivery. Analysis of comments made by county and parent interviewees suggests that CASSP's impact on increasing family participation was especially notable in the areas of staff and parent training, empowerment of individual parents, and organization of local and state parent groups.

Cultural Competence
Informants were asked to rate the extent to which their county valued cultural competence in service systems for children and adolescents with SED. It is in this area that county agency staff and parents of youth with SED most differed in their perception of county service systems. Indeed, almost two-thirds of county agency staff reported that their county placed significant or extensive value on moving systems of care toward becoming more culturally competent while two-thirds of parents reported that their county placed no, minimal, or some value on this issue. One possible interpretation of these findings is that, although service agency personnel have become increasingly aware of the importance of making service delivery culturally competent, changes have not yet been implemented at the direct service level

and have therefore not been perceived by service consumers and their families. Overall, results suggest that the perceptions of modest improvements in the cultural competence of service delivery were due in part to CASSP's efforts to inspire county mental health administrators to become leaders in the movement to establish culturally competent systems of care for children and adolescents.

Return to Top

System Change and Outcome

When asked whether or not they believed systemic changes had occurred in their county's service delivery system for children and adolescents with SED, almost three-fourths of county agency staff and over half of parent informants responded yes. However, when asked to rate the extent to which the human service needs of children and adolescents with SED in their county were being addressed, over two-thirds of county agency staff informants and almost three-fourths of parent informants reported that those needs were addressed minimally or not at all. Several respondents noted that, although many of the needs of children and adolescents who have been identified are being addressed, there are many more youth with SED who are not yet identified by the system.

In summary, the major findings regarding the perceptions of county service agency staff and parents of children and adolescents with SED about the impact of CASSP in California and changes in systems which serve youth with SED are as follows:

1. a majority of both groups state that CASSP has had some impact on improving interagency collaboration between county human service agencies;
2. both groups feel that human service agencies are working together in important ways, though human service agency staff are more in agreement with this statement;
3. both groups feel that CASSP has had some impact on parent involvement in mental health service systems for children with SED;
4. generally, both human service agency staff and parents of children with SED state that mental health service providers are more aware and supportive of parents and families of children with SED than they were four years ago;
5. human service agency staff report the perception that agencies highly value cultural competence in service delivery while parents of children with SED report that agencies minimally or somewhat value this concept;
6. both human service agency staff and parents of children with SED feel that there has been a systemic change in service delivery systems to children with SED over the last four years; and
7. on average, human service agency staff feel that the needs of children with SED are being adequately met, while the majority of parents state that such needs are only minimally met.

Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Evaluation of the California Implementation of the Child and Adolescent Service System Program: A Review of Documents

Authors

Introduction Methods Results Discussion References
Return to Table of Contents

Introduction

The Child and Adolescent Service System Program (CASSP) in California is designed to compel system of care development for children and adolescents with serious emotional disturbance. As part of the evaluation of the CASSP in California (Madsen, Dresser, Rosenblatt & Attkisson, 1994), a review of documents was conducted to gain an understanding of the status of human service reform efforts in California. Documents reviewed include: (1) federal system of care policy and program descriptions; (2) state memoranda, documents, and reports relevant to CASSP implementation in California; (3) reports from county administrators involved with system of care development; and, (4) child advocacy and parent support group newsletters and monographs. The goal of this review of written products was to provide a broad context within which to assess
CASSP contributions in California.

Return to Top

Method

Documents were identified for review after consultation with state and county administrators, human service and research professionals, parents, and child advocates. Additional documents were also selected from the emerging literature on the design and evaluation of systems of care in California. Altogether, thirty-five documents representing over 7,500 pages of text were selected for review. The documents selected for review were organized into four broad types to enable reviewers to consider aspects of service system development from the perspectives of federal, state, county, and consumer participants in the reform process (See Table 1). Reviewers developed detailed notes on the content of each document. From the notes, major themes, continuities, and discontinuites across documents were identified by project staff
and synthesized into a summary of document contents.

Return to Top

Results

The results section provides a summary of major themes and continuities regarding human service reform in California. While there was some variation in coverage and emphasis across documents (see Madsen, Dresser, Rosenblatt & Attkisson, 1994), the content of the documents relate to one of three themes: (1) challenges facing California; (2) factors that facilitate human service reform in California; and, (3) CASSP contributions in California.

Challenges Facing California

California faces many challenges to state-wide human service reform. Described below are a few of the challenges discussed by document authors.

1. Geographic and Population Scope and Diversity. California's population is nearly 32 million people. The state has the seventh largest economy in the world (3)*. There is a diversity of geopolitical regions (urban, suburban, rural, mixed) and extraordinary ethnic diversity in many parts of the state. Population growth is driven in great part by immigration. Most immigrants to California are ethnically diverse people of child bearing age from Mexico, Central and South America, Pacific Rim, and Asian lands (4).

Geographically large, densely populated, and ethnically diverse regions of the state with large numbers of low income residents (e.g., Alameda, Los Angeles, and the large southern counties of the state) pose special challenges to adequate service provision. Human service providers are challenged to become more knowledgeable and sensitive to the culturally specific needs of ethnically and economically diverse populations of children and families. Public schools in a number of California counties face complex problems stemming from large numbers of non-English language speaking children coupled with inadequate numbers of cross-culturally trained and bi- or multi-lingual educators (9).

2. Economic Recession and Erosion of the Tax Base. The last national economic recession produced severe contractions in California's construction, computer, and defense industries and resulted in a decline in the average earnings of Californians. Hardest hit were the lowest 40 percent of wage earners, the unemployed, and the very poor who are most dependent on public services (3).

The erosion of California's tax payer base provides less opportunity for local governments to keep pace with increased case load demands for public service. Voter and legislative initiatives, such as the Proposition 13 limitations on property taxation, the Proposition 98 set-aside of 40% of state funds for K-12 education, and the Gann limits on state spending, have severely curtailed the proportion of the state budget available for discretionary spending. Increased demand for public services is difficult to accommodate in California, where over 90% of the state budget is allocated to fixed costs and entitlement programs.

3. Complex, Convoluted and Inflexible Funding. Health and human service administrators in California must navigate a complex array of federal, state, and local funding streams and private sector (insurance or foundation) support to marshal resources on behalf of children and youth. There are no less than eight federal funding streams relevant to mental health services alone, each of which finance very specific services to a very narrow target population of youth.

A study conducted by an external consultant to the California State Department of Mental Health (2) revealed that California could significantly expand resources available for prevention efforts and community based services by lifting self-imposed limitations on access to and use of federal entitlement funding streams. Additionally, financial incentives are typically structured into the formulas for calculating in-home vs. out-of-home placement rates for each public human service sector in California &shyp; mental health, child welfare, juvenile justice and special education. Across the board, state and county cost sharing ratios produced incentives for counties to shift costs to the state through increased reliance on out-of-home placements (11).

4. Lack Of Objectives and Accountability. Human service delivery systems throughout the state generally suffer from a lack of well-defined objectives, and a lack of accountability for documenting child, youth, and family outcomes. Without clear service objectives, and criteria for evaluating effectiveness, administrators and providers operate within a performance and information vacuum.

Factors that Facilitate Human Service Reform in California Factors that facilitate human service reform in California include policy, fiscal, and programmatic changes that have been influenced by national trends, funding opportunities, state legislation, activist government, and parent leadership. Below are a few of these factors.

1. Mental Health Program Realignment. Program Realignment (AB 948, the Bronzon-McCorquodale Act of 1991) is a legislative change in California with far reaching consequences for the financing, organization and delivery of mental health services. Program Realignment was prompted by the state budget crisis (a $14 billion dollar state budget deficit in FY 1991-92) and constraints on the state budget process limiting discretionary expenditures for health and human services. The bill realigns fiscal responsibility by shifting costs, control, some revenue generation, and responsibility from the state to counties for public mental health, public health, some social services, and some state psychiatric hospital and locked facility beds. The cost shifting involves over $2 billion dollars worth of service provision annually (3). Realigned programs are funded through increased vehicle license fees and a permanent one-half cent sales tax increase. Formal research and evaluation of Program Realignment in California is not yet complete.

However, an interim assessment (7) notes improvements in state financing of mental health services derived from Program Realignment. The improvements stem from: (a) a guaranteed revenue stream which enables county administrators to plan ahead and county governments to serve as more reliable contracting partners; (b) relaxed financing restrictions of state bureaucracy which enables counties to use de-categorized Medi-Cal and private funds more aggressively and carry over unexpended funds from one fiscal year to another; and, (c) increased county fiscal responsibility for service provision which shifts the incentive structure away from high rates of utilization of expensive institutional services.

2. Managed Mental Health Care. The California Department of Health Services (DHS) managed care initiative (6) integrates California's two Medi-Cal funding streams for mental health services (Short-Doyle/Medi-Cal and Fee-For-Service/Medi-Cal) and places Medi-Cal mental health services under the domain of county mental health departments. Counties have a choice to serve as the Local Managed Mental Health Care Plan (LMMHCP) offering an array of services that emphasize prevention, promotion of health and functional ability, and decreased reliance on hospital and institutional services. In the managed care plans, individual providers are linked together under the umbrella of the LMMHCP. All eligible Medi-Cal beneficiaries receive their mental health services through the LMMHCP in accordance with access criteria and standards set by the state and Medicaid.

3. System of Care Development. Legislatively enabled, state funded, and independently evaluated systems of mental health care are evolving in an expanding number of California counties (Rosenblatt, Attkisson & Fernandez, 1992; Rosenblatt & Attkisson, 1992, 1993; Attkisson & Rosenblatt, 1993; Attkisson, Dresser, & Rosenblatt, in press). System of care efforts were inspired and given definition by leaders from Ventura County in conjunction with local and state political representatives. Building upon CASSP principles, the Ventura leaders devised a planning model for reform of mental health service delivery (Feltman & Essex, 1989; Jordan & Hernandez, 1990). Following the planning model, Ventura successfully implemented community based mental health services for disturbed youth, demonstrated improved youth outcomes, and decreased overall expenditures. The initial 1984 demonstration in Ventura County (AB 3920) was expanded in 1987 to Riverside, San Mateo, and Santa Cruz (AB 377). More recently, through new legislation (AB 3015 passed in 1993), the California Model System of Care was extended to an additional seven counties: Humboldt, Los Angeles, Merced, Monterey, Placer, San Luis Obisbo, and Stanislaus. San Francisco county pursued a system of care demonstration in the Family Mosaic Project with grant funds from the Robert Wood Johnson Mental Health Services Program for Youth (8).

Collectively, system of care counties work toward desired outcomes for targeted populations of youth with serious emotional disturbance: controlled rates of out-of-home and state hospital placements and associated lower costs, improved school attendance and academic performance, and decreased juvenile justice recidivism. The system of care counties are implementing community based mental health services that involve improved financing for consumer choice and flexibility and individualization of service delivery. Parental, extended family, and foster family participation in program and treatment planning is an essential component of the California system of care movement. Other programmatic features include centralized and strategic case management to avoid unnecessary out-of-home placement, multi-agency coordination and treatment team approaches, and cultural competence of service delivery (10). The combination of demonstrating positive client outcomes while controlling public costs for services provided through multi-agency collaboration has facilitated tremendous support and momentum for systems of care in California.

CASSP Contributions in California

Significant CASSP contributions in California include:

1. Dissemination of System of Care Principles. Information dissemination regarding system of care concepts, along with funding opportunities for local system of care development, produced the knowledge and incentive systems necessary for the formation of a critical mass of system of care proponents throughout California. The CASSP provided organizing energy, technical assistance and formal trainings to county administrators, human service professionals, and parent groups seeking to improve local systems of care, enhance cultural competence of service delivery, and increase parent involvement in service systems for children and youth with serious emotional, behavioral and mental problems. Since CASSP development in California, system of care principles became an organizing theme for mental health service system development as reflected in the California State Mental Health Plans, the State Master Plan, county planning documents, system of care expansion and evaluation, and shifts in Medicaid funding policy. The system of care philosophy has been disseminated successfully among the California Mental Health Planning Council and the California Mental Health Directors Association, along with other key state-wide policy and planning groups.

2. Formation of Broad-Based Advisory and Advocacy Groups. The CASSP supported the development of a state-wide multi-agency policy process through the role of the State
CASSP coordinator on the State Interagency Advisory Council for Systems of Care (SIACSOC). Additionally, CASSP launched and supported the development of a formal family advocacy capacity in California by providing focused, ongoing assistance to parents involved with creating and growing the Family Network of California (FNC) and the United Advocates for Children of California (UACC) (5). CASSP also created a state-wide Cultural Competence Advisory Committee (CCAC) aimed at improving the cultural competence of service delivery to California youth and their families.

Return to Top

Conclusions and Implications

In summary, despite significant challenges and obstacles to reform, a human service reform movement is underway in California; this movement has been inspired and supported by the national movement for integrated systems of care as exemplified by the Child and Adolescent Service System Program of the National Institute of Mental Health. The reform movement gained ground steadily in California during CASSP years, as evidenced by system of care expansion, mental health policy and financing changes, and increased leadership and activism on behalf of children, youth, and their families. Three thematic findings emerge from the review of documents:

- There is a striking degree of consistency and agreement across sources about the identification of problems and level of progress achieved in reforming human services to meet the needs of California youth with serious emotional disturbance;
- Human service reform is uneven across California counties, with state-funded, integrated system of care counties existing alongside counties apparently uninvolved in reform efforts; and
- CASSP is a positive and constructive influence on human service philosophy, policy, and programs in California. Document authors emphasize CASSP contributions with respect to disseminating system of care principles and philosophy, and in fostering parent advocacy and multi-cultural involvement in mental health planning and policy making. State memoranda and reports document CASSP efforts and activities throughout California. County administrator reports and monographs reflect the positive role CASSP plays in local system of care development and enhancement. Parent advocates note the positive role CASSP serves in support of advocacy efforts.

Return to Top

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Return to Top

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Return to Top

*Numbers in parentheses refer to reports listed in Table 1. Return to Article

[Home] [Search] [Index]

Table 1

Return to Article

Table 1
A Sample of Reviewed Documents

Federal government reports & monographs:

1. *A System of Care for Severely Emotionally Disturbed Children and Youth.* July, 1986. Beth A. Stroul and Robert M. Friedman. Available from CASSP Technical Assistance Center, Georgetown University Child Development Center, 3800 Reservoir Road, NW, Washington, D.C. 20007. 148 pages.

State memoranda, documents and reports:

2. *Assessing and Planning for the Expanded Use of Title IV-E and Title XIX in California.* February 15, 1990. Submitted to the State Department of Mental Health by the Institute for Human Service Management, 7307 MacArthur Blvd., Bethesda, MD 20816. 118 pages.
3. *California Mental Health Plan.* Annual editions from 1987/88 thru 1992/93. Available from the State Department of Mental Health, 1600 Ninth Street, Sacramento, CA 95814. 541 pages.
4. *California State Census Data Center Newsletter.* Vol 11, No. 4, January, 1994. Produced by the State Department of Finance, 915 L Street, Lower Level, Sacramento, CA 95814. 7 pages.
5. *Family Network of California (FNC) Meeting Notes and Memoranda,* 1990-93. Compiled by Rachel Guerrero, Program Director, Child and Adolescent Service System Program (CASSP), State Department of Mental Health, 1600 Ninth Street, Sacramento, CA 95814. 336 pages.
6. *Managed Care for Medi-Cal Mental Health Services, October 4, 1993.* Available from State of California Department of Mental Health, 1600 Ninth Street, Sacramento, CA 95814. 45 pages.
7. *Summary of the Town Hall Meeting on Program Realignment, May 27, 1992.* Available from Brian Cuffel, Ph.D., The Institute for Mental Health Services Research, 2001 Addison Street, Suite 200, Berkeley, CA 94704. 34 pages.
8. *The Robert Wood Johnson Mental Health Services Program for Youth, State of California Phase I and Phase II Applications,* February 1, 1989 and March 13, 1990. Developed by the State Department of Mental Health and the City and County of San Francisco Department of Public Health, Division of Mental Health and Substance Abuse, 1380 Howard Street, San Francisco, CA 94102. 584 pages.
9. *The State of the State's Educational Enterprise: An Overview of California's Diverse Student Population,* 1993. Produced by the California Post Secondary Education Commission, 1303 J. Street, Suite 500, Sacramento, CA 95814-2938, 6 pages.

County administrator reports & monographs

10. *AB 377 Plans and Reports of Riverside, San Mateo, and Santa Cruz Counties.* 1989 - 1993. Submitted to the California Department of Mental Health by Riverside County Department of Mental Health, San Mateo Mental Health Services Division of the Health Services Department, and Santa Cruz Health Services Agency, Division of Community Mental Health Services, Children's Mental Health Services, each along with collaborating county social services, probation and education agencies. Available from the State Department of Mental Health, 1600 Ninth Street, Sacramento, CA 95814. 682 pages.
11. *The Reasons to Invest in the Families of California: Reasons to Invest in Services which Prevent Out-of-Home Placement and Preserve Families.* Spring, 1990. Prepared and published by the County Welfare Directors Association of California, the Chief Probation Officers of California, and the California Mental Health Directors Association through a grant from The Edna McConnell Clark Foundation. Available from the County Welfare Directors Association of California, 1010 11th Street, Suite 310, Sacramento, CA 95814. 35 pages.

Advocacy group newsletters & monographs

12. *Fighting Fragmentation: Collaborative Efforts to Serve Children and Families in California's Counties.* 1991. H.N.L. Chang, S. Gardner, A. Watahara, C.G. Brown and R. Robles. A Joint Publication of California Tomorrow and The Children and Youth Policy Project, University of California, Berkeley. Available from California Tomorrow, Fort Mason Center, Building B, San Francisco, CA 94123. 58 pages.
13. *Upwards: A Newsletter of the United Parents.* Editions from Vol I-III, September/October, 1991 to July/August, 1993. Published bi-monthly by the United Parents. Available from United Parents, c/o Ellen Linder, P.O. Box 1839, Moorpark, CA 93020-1839. 75 pages.

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[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Issues in Implementing a Randomly Assigned Study Design in a Community Setting: Lessons from the Vanderbilt/Stark County Evaluation Project

Authors

Introduction Methods Discussion References
Return to Table of Contents

Introduction and Program Description

As the first study conducted to examine the clinical outcomes of a publicly funded system of care using a randomly assigned sample, the Stark County Evaluation Project encountered numerous methodological challenges. The purpose of this summary is to describe the process of implementing the study design, as well as to discuss the various decision-making mechanisms utilized and lessons learned.

To date, there is no scientific evidence that the expanded care system is more clinically effective than traditional services. The recently completed Fort Bragg evaluation found that a continuum of care was not more effective than a traditional insurance system for military dependent children (Bickman, Guthrie, Foster, Summerfelt, Breda, & Heflinger, 1995). The primary aim of the research project was to assess the extent to which an expanded system of individualized care leads to improvements in the clinical functioning of children with severe emotional disturbance and their families. This research/demonstration was distinctive in that it examined the effects of change in an expanded system of care, in contrast to studying changes in individual components of the system (e.g., case management, intensive home treatment) and did not study a specially designed demonstration project but services provided without special funding. The site chosen for the study was Stark County, Ohio, a county which has several years experience of collaborative efforts in implementing a coordinated system of care.

The Stark County project focused on two key questions:

- What are the outcomes of an expanded system of care on the clinical functioning of children with severe emotional disturbance and on the functioning of their families?
- What are the individual child and family factors that influence the outcomes?

This summary of the Vanderbilt/Stark County Project will address process issues critical to implementing the research design. Outcome data will be published when the study is completed.
Return to Top

Method

Criteria for Inclusion
Participants were 360 children and adolescents (Stark County residents) who are between the ages of 5 and 17.5 years inclusive, with indications of Severe Emotional Disorder (SED), and who were involved in at least one child-serving system (Department of Human Services (DHS), Education, or Juvenile Justice). Participants were recruited through several intake points with DHS and Child and Adolescent

Service Center (C&A), the child-serving community mental health agency. Children referred from DHS were screened by C&A and met intake criteria for C&A expanded services before a child was determined eligible for the study.

Random Assignment
A unique aspect of this study was the random assignment of children. Study participants were randomly assigned to receive the expanded services through C&A or standard care from community agencies outside of C&A. The random assignment procedure was felt to be the most valid scientific design that would enable us to determine if the expanded services were effective. Under this procedure, all participating children had an equal chance to receive the expanded services. Families were told about the two treatment conditions during the informed consent process, but they did not know to which condition their child was assigned until after the initial study interview. The study was designed to ensure that participants remained in the group to which they were assigned until data collection was completed.

Data Collection
The interviews with parents, foster parents, children and adolescents were conducted initially, and every six months for three waves of data collection. Participants received a combination of computerized, written, and, at follow-up, telephone interviews. The baseline data collection included self-administered computerized and written interviews. During follow-up interviews, all information was collected by phone or mail.

Return to Top

Lessons Learned

Cooperative management was accomplished through a steering committee composed of representatives from Vanderbilt, Mental Health, and Department of Human Services. Monthly meetings were held to identify problems, air concerns, sort out turf issues, and reach decisions on how to address concerns. Good communication and the ability to remain flexible were key elements in project management. Identification of roles for each organization was crucial for implementation. Development of procedural protocols was also important.

Vanderbilt played the role of providing data regarding recruitment, documenting services provided to clients, and encouraging the maintenance of standards required by the research design. Mental Health and Department of Human Services used the monthly meetings to continually coordinate their efforts at identifying untapped pools of potential participants, and to develop procedures for accessing those potential participants for the study.

During implementation, barriers to success of the project were identified and addressed by the steering committee. The major barriers pertained to ethical concerns and participant recruitment.

Ethical Concerns
In implementing the research project with random assignment, several ethical questions had to be addressed. Those questions were raised by direct care providers in an effort to assure themselves that they were in compliance with their professional ethical standards. The ethical concerns raised were as follows:

1. Is it ethical to deny the control group access to a system of care that providers believe to be the best way of providing service to families?
2. In such a study, is it ethical and/or practical to ask C&A therapists and case managers to provide limited service to control group subjects? That is, should the project attempt to treat the control group within the system but withhold the expanded services?
3. Should experimental group clients be required to see only system of care therapists for services? Is it possible that a case manager could coordinate the service plan with a private therapist or provider from another agency?

4. If a control group client decided that they want to seek system of care services, can we deny access to those services?

The steering committee used the Ethical Principles of Psychologists and Code of Conduct (APA, 1992) as their guide in addressing these questions.

In addressing the first ethical concern, the steering committee debated the issue of professional opinion versus existing research findings. In his role as principle investigator, the Director of the project provided information substantiating the fact that no experimental studies have been conducted on this matter. It was the opinion of the steering committee that these were indeed professional opinions and not matters of fact. Therefore, there was no ethical bind for providers of service to participate in the study with knowledge that control group would not have access to the system of care.

In regard to the second question, it was decided by the steering committee that it was not practical to ask system of care (experimental group) therapists to provide services to both the experimental group and control group subjects. Moreover, based on ethical issues, it was important to C&A that control group participants not be clients in their treatment system. By serving them outside of C&A, they were not in the role of denying services.

Regarding question number three, it was decided that it was possible for a case manager from an experimental group participant to coordinate services with providers from any agency. This is indeed the work they do on a regular basis. Therefore, it was not considered to be an undue burden or an ethical concern for case managers to work with system of care therapists and/or therapists from other agencies or private practice.

Regarding question number four, it was decided that if a control group subject decided to seek services from the system of care that they are in effect, dropping out of the study. However, detailed procedures were developed to assist those clients in finding other satisfactory providers that are not part of the system of care. By providing this assistance to clients who were not satisfied with their current provider, it allowed the study to maintain subjects in a more true control group setting as opposed to mixing part of their treatment with system of care therapists. It would have been clearly unethical to simply deny the client's request for the sake of the study. Once the client had dropped out however, they may request any service without restriction.

Subject Recruitment

Recruitment of subjects emerged as a difficult issue in the study. Mental health did not have the volume of clients to supply 360 subjects within the specified time frame of the research project. Department of Human Services (DHS) had the volume of clients, but lacked the clinical expertise to judge appropriateness of referrals for the study. Juvenile Court had problems similar to DHS. Schools had the volume, but were hesitant to engage in experimental research because of potential public relations problems.

In the end it required a collaborative effort between Mental Health and Department of Human Services with much encouragement from Vanderbilt to recruit enough participants for the study. That collaborative effort consisted of Mental Health providing consultation in the form of screening potential referrals from DHS before the referral was actually made to Vanderbilt. This assured appropriateness of participants referred for the study and increased the volume to a level that would allow us to reach 360 subjects within the time frame of the study. Other procedures were developed to recruit from juvenile justice as well as from local school systems. These efforts, however, were largely unsuccessful.

Finally, procedures were developed for recruiting from area United Way agencies. These efforts were initiated by Mental Health because of their existing relationship with United Way. After initiating the dialogue, the Vanderbilt staff then followed up and designed procedures that would allow them to receive referrals directly from United Way agencies. Because of the amount of time involved in working out such collaborative procedures, it placed significant pressure upon Vanderbilt as the primary investigator in this project to maintain the study within the time frame specified with the National

Institute of Mental Health.
Return to Top

Summary

Collaboration between Vanderbilt, Mental Health and the Department of Human Services was crucial in addressing methodological and procedural issues to maintain the experimental design. Future community-based research efforts would be well advised to establish a steering committee to assure good communication and successful implementation of research design.

The Vanderbilt/Stark County Evaluation Project is the first study to examine clinical outcomes in a publicly funded system of care using random assignment of subjects. The study has two key questions. One was to evaluate what the outcomes of a systemic approach to care are regarding clinical functioning of children with SED and their families. A second question was to look at what individual and family factors influence outcomes.
Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Evolutionary Changes in a Local System of Care for Severely Emotionally Disturbed Children and Adolescents: The Pendulum is Swinging

Authors

Introduction Methods Discussion
Return to Table of Contents

Background

For the past decade, the pendulum for children and adolescent mental health services in Region II in Louisiana has been swinging from traditional institutional care to services that are child-centered, family and community-based. As the pendulum has swung, a continuum of services has developed that allows families of children and adolescents with severe emotional disturbances to choose from an array of services ranging from traditional inpatient care to home-based services. A goal of the developing system is to become a "one-stop" and "user friendly" system of care. This paper describes our system of care and all of its service options. Further, this paper describes a plan that is being developed to collect data from the system so as to objectively and scientifically study the effectiveness of the system as a whole and its individual parts.

Region II of the Office of Mental Health in Louisiana serves seven parishes. The Margaret Dumas Mental Health Center (MDMHC) serves children ages 6 to 18 in Baton Rouge and the surrounding parishes. East Baton Rouge Parish is the largest urban area in the region with the outlying parishes being mainly rural. There are over 8000 children with severe emotional disturbances under the age of 18 in this seven parish area. This figure is based on an estimated five percent of the population. Many of the children in the area are served through the psychosocial rehabilitation option plan funded by Medicaid. Those served through the MDMHC have access to the continuum of care discussed below. The majority of cases at MDMHC have been of the lower socio-economic status and uninsured.
Return to Top

The System of Care
On a continuum from least restrictive to most restrictive, our current system of care includes family support groups, educational groups, traditional outpatient counseling, home and school-based services, case management services, respite services, home companions, school companions, intensive home-based crisis counseling, runaway watch, suicide watch, therapeutic foster care, day treatment and inpatient treatment. A child or adolescent may move in either direction on this continuum at any time during his/her treatment. Each treatment plan is tailored to meet the individual's and family's specific needs. The following are descriptions of each treatment option.

Family Support Groups: A local chapter of the Louisiana Federation of Families for Children's Mental Health is operated through the Margaret Dumas Mental Health Center and meets regularly to provide support for families of emotionally disturbed children/adolescents. They also maintain a resource library which contains information pertaining to mental illnesses and other relevant topics.

Educational Groups: Currently providing three educational groups: Attention-deficit Hyperactivity Disorder, Anger Management, and Parenting Skills. Open to children and families receiving mental health services.

Traditional Outpatient Services: Traditional counseling and medication services at the mental health center by appointment or in emergency situations. Three social workers, one psychologist, and three part-time psychiatrists provide services.

Home and School-Based Services: Traditional counseling services, but within a more natural setting, such as the child/adolescent's home and school.

Case Management: Assistance with a variety of physical, social, and recreational needs of the child and family; assistance includes coordination of services received and an advocacy role.
Brief in-home or out-of-home services: Supervision of the child/adolescent is provided by paraprofessionals. Allows primary caregivers to have time off from supervisory responsibilities. Includes both planned and emergency respite.

Home Companion: A paraprofessional maintains one-on-one contact with the child/adolescent during a specified period of time within the home. Assists with supervisory duties to relieve primary caregivers.

School Companion: A paraprofessional maintains one-on-one contact with the child/adolescent during a specified period of time within the school. Assists teacher in keeping the child/adolescent on task and in maintaining self-control.

Intensive Home-Based Crisis Counseling: A four to six week program of intensive home-based counseling to prevent out-of-home placement of the child/adolescent. The child/adolescent must be at moderate risk for out-of-home placement within the next few months to qualify.

Runaway Watch: 24 hour, one-on-one coverage for the child/adolescent who is a significant threat to runaway from home. Allows primary caregivers to sleep at night, etc. Attempts to prevent out-of-home placement of the child, and is an alternative to hospitalization.

Suicide Watch: 24 hour, one-on-one coverage for the child/adolescent who is a significant threat to commit suicide. Allows primary caregivers to sleep at night, etc. Attempts to prevent out-of-home placement of child and is an alternative to hospitalization.

Therapeutic Foster Care: Temporary placement of the child/adolescent with a foster family for up to four months while problems with family or environment are resolved. An alternative to hospitalization.

Day Treatment: Mental Health Services provided on a daily basis within a structured setting. However, the child/adolescent returns home each night. An alternative to hospitalization.

Inpatient Treatment: Hospitalization for intensive inpatient services. Most restrictive of all options.

Return to Top

Barriers

While the system of care provides many treatment options, it is limited in its resources. Inherent in the task of developing a system of care for the children in Region II is the need to create a stable, long-term financing mechanism to support both the development and the operation of such systems. Presently in Louisiana, there is not a special children's mental health budget. All funds over annually budgeted means of financing generated by either adult mental health or children's mental health services are returned to the State General Fund. This mechanism not only handicaps the day-to-day operation of the mental health system but also limits the possibilities of pursuing Federal Grants. On many occasions, the State was not able to meet the grant requirement of coming up with "matching funds." A creative way of generating and managing a special fund for the system of care is needed. Due to these funding restrictions, resources have to be monitored carefully. Therefore, it is imperative that the components of the system be evaluated so that the most effective components are available to the most people in need. We are in the process of developing a program to evaluate the effectiveness of the system.

In addition to the barriers presented by funding problems, there are also transportation problems for the clients and a need for more clinical and clerical staff. Other aspects of the program that we would like to see added to the continuum of care include an after school program and more recreational services.

Data being monitored include broad demographic characteristics to allow studies on urban vs. rural factors, age, racial, gender, and economic factors, and individual school factors. Other data collected include diagnostic information, medications, service utilization (least restrictive to most restrictive), hospitalizations, and other treatment factors. These data will allow us to formally evaluate effectiveness and to perform studies aimed at deriving predictor variables which will help plan our system more efficiently. If we can determine specific characteristics of clients that predict success or failure within a specific component of the system, we will be able to more efficiently use the limited resources we have.

Return to Top

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Return to Top

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Arizona's Implementation of Managed Care in the Public System: A State's Perspective

Authors

Introduction Methods Results Discussion References
Back to Table of Contents

Introduction/Purpose

This report provides a historical review of changes in Arizona's behavioral health system which occurred during the past four years. These changes were designed to develop public sector Managed Behavioral Healthcare Organizations for children and adolescents. Using managed care principles, the use of costly inpatient/institutional care was decreased, while community-based outpatient care increased. A review of service utilization data is included which supports the transition from a fragmented fee-for-services system of care to the current level of system development.
Return to Top

Method/Procedures

This project involved the review of historical documents, including state and federal legislation, state plans and waivers, intergovernmental policies and agreements, reports, memos, and contracts which tracked the multi-year system changes within the state's behavioral health system. As these changes were implemented over a four year period, client and service data were collected which described utilization under the previous fee-for-service system. These data were compared to client and service data reported since the development of the current managed care system.

Subjects/Sites

Client and service data from the four year transition period were reviewed for all Arizona children presenting with behavioral health needs, regardless of income and level of need. Data for this review period were selected from the state's management information system, selecting those children receiving at least one state-funded behavioral health service through contracted community-based regional behavioral health authorities or their subcontracted providers.

Intervention/Program

Six Regional Behavioral Health Authorities (RBHAs) serving children and families in Arizona are located throughout the state. These are private non-profit corporations which receive funds through contracts with the state to administer behavioral health programs. These RBHAs subcontract with local service providers, providing community-based delivery systems within their designated geographical boundaries, creating provider networks. The RBHAs also provide a case management system designed to provide authorization and conduct utilization review.

Arizona state statute 36-264 requires a Medicaid financial eligibility screening prior to the utilization of publicly funded behavioral health services by children and adolescents. Once this screening completed, the child behavioral health assessment. As a result of the assessment, a behavioral health treatment plan may be developed.

Approval for services is based on medical necessity. Medical Necessity stipulates (1) A child requires a particular type of service; and (2) the child will benefit from that service based upon diagnosis, presenting problems, intensity of service need, and expected response (outcome). For admission to inpatient or residential treatment centers and partial care programs, level of care criteria are imposed which also facilitate overall requirements of medical necessity and impose RBHA case management designed for control of utilization. The required RBHA Prior Authorization is determined by a clinical team of psychiatrist, case manager, and masters-level supervisor, and it applies for any child entering out-of-home care.

Referral into the RBHA managed care system results in two distinct avenues, one for children entitled to behavioral health services under Medicaid, the other for those not meeting Medicaid entitlement, but meeting medical necessity eligibility. In addition to level-of-care evaluation to control utilization, intensive case management services are assigned to children with a diagnosis and presenting with a functional score indicating critical severity of need. The Children and Adolescent Functional Assessment Scale (CAFAS; Hodges, 1990) is used as the functional assessment instrument. Intensive case management acts as gatekeeper for restrictive services. RBHA intensive case management personnel work under the direction of board-certified psychiatrists, and develop an Individual Service Plan, addressing medical necessity, appropriateness of services, prior authorization, and service utilization issues.

After a child is placed in inpatient or institutional care, ongoing utilization reviews are conducted by the RBHA to determine appropriateness of placement. At this point, the case manager, via the clinical team, may request continued placement based on medical necessity. If denied by the RBHA clinical review team, the child is then transferred to a less restrictive treatment environment, such as community-based therapeutic group home, behavioral health group home, group home, therapeutic or non-therapeutic foster care, or return to home. Each of these placements may be supported by optional outpatient services, ranging from partial care programs to home-based counseling.

Measurement/Instruments

Client and service data were reviewed for utilization patterns under the previous fee-for-service system. These data were then compared to client and service data to determine utilization trends under the current managed care system. During the four year period of review, initial data reflected utilization patterns for a mixed capitation fee-for-service system. RBHAs were paid a monthly capitation amount for case management, transportation and assessment services, while their subcontracted providers were paid on a fee-for-services basis at pre-set maximum capped rates. These rates were projected, using past utilization and market rates. Later, under a fully imple-mented managed care system in which RBHAs were paid a monthly capitation amount based on prior enrollment, assuming risk for all services in the continuum of care, data were also tracked for utilization patterns. In this scenario, RBHAs authorized services through the state's manage-ment information system, and their subcontracted providers presented claims for reimbursement by the state's third party payor.

Return to Top

Results

In Figure 1, service utilization data depict the average days of all admissions to out-of-home services over the past four years. Figure 2 reports the number of children (unduplicated count) receiving out-of-home services. As seen in these Figures, the average number of days in an inpatient/RTC setting decreased while the overall number of children receiving this service increased. The increase in utilization seen in 1992 is thought to be reflective of the state's policy to bring children from other state agencies into the Medicaid program, many of which enter the behavioral health system from an inpatient setting.

The data for children in other out-of-home programs such as therapeutic group homes has shown a decrease during the review period as has the average days in these programs. It should be noted that these out-of-home services are provided in an "unbundled" fashion: a basic room-and-board service fee is billed separately, along with any required therapeutic services, and each component may be paid, provided, and recorded separately. For example, the room-and-board cost may be paid by other funding sources such as a child welfare agency and may not be accounted for in the behavioral health management information system. Because of this, it may not be possible to capture the exact number of children receiving behavioral health services in a less restrictive out-of-home program. Therefore, some under-reporting of the number of children in these out-of-home services may be evident. Moreover, the standard deviations on average stay were unavailable, thus caution should be used in interpreting these results.

Figure 3 reveals that the average number of days of non-residential services remained the same throughout the four year period. This is remarkable when one considers the number of children (unduplicated count) receiving these services (see Figure 4). The number of children receiving in-home services increased five-fold over the four year period, while those children receiving services through a partial care program doubled during the same period.

Return to Top

Implications

Preliminary data suggest that Arizona's attempt to provide behavioral health care in a publicly administered environment has yielded positive results. Managed care principles in the public sector can be effective in reducing the utilization of inpatient/residential care for children and adolescents. Additionally, the increase in utilization of non-residential services may indicate that community-based services are a contributing factor in the management of behavioral health services for children and adolescents.

Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

Figure 1

Return to Article

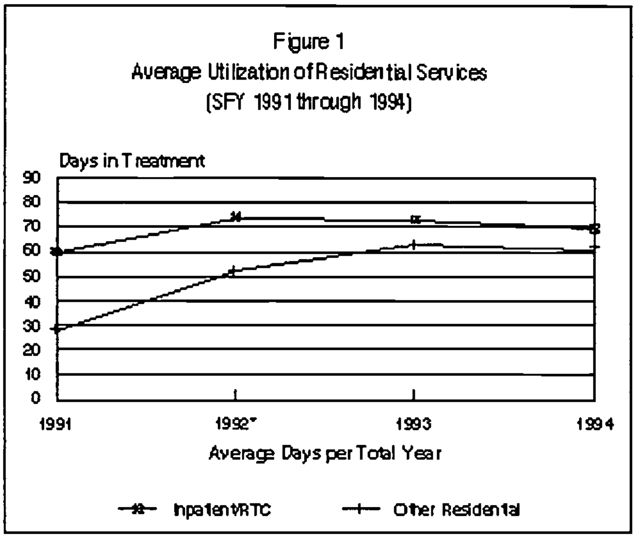


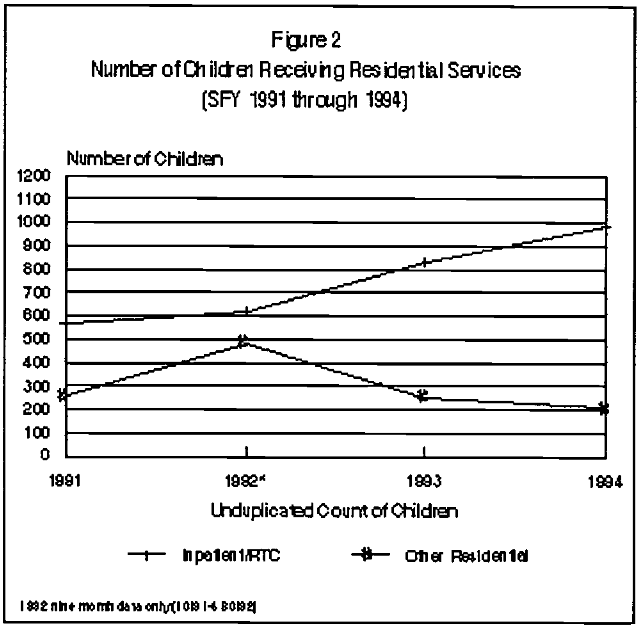
Figure 1
Average Utilization of Residential Services
(SFY 1991 through 1994)

BEST COPY AVAILABLE

[Home] [Search] [Index]

Figure 2

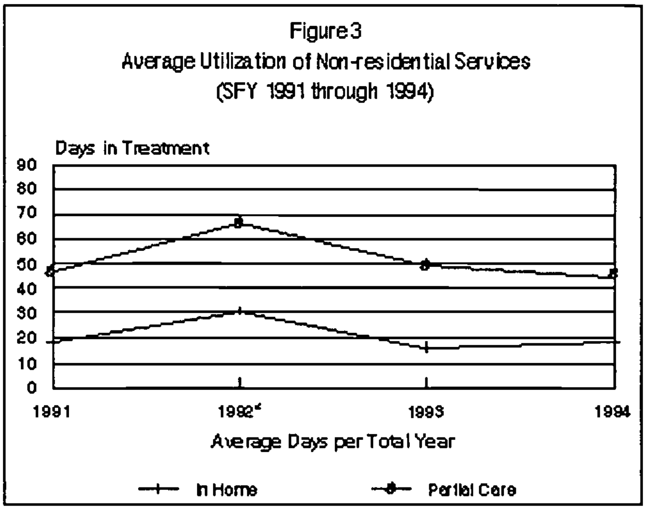
Return to Article



[Home] [Search] [Index]

Figure 3

Return to Article

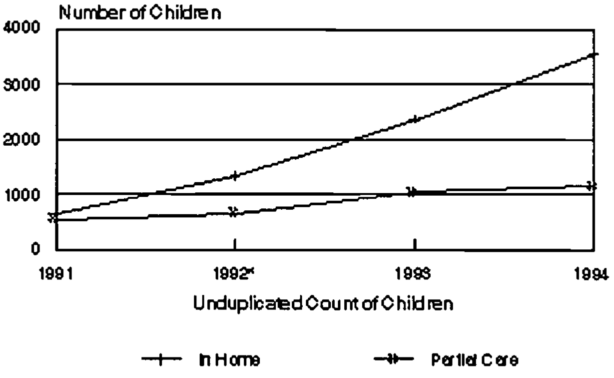


[Home] [Search] [Index]

Figure 4

Return to Article

Average Utilization of Residential Services
(SFY 1991 through 1994)



1992 nine month data only (10/91-6/30/92)

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies,
Florida Mental Health Institute, University of South Florida,1996

The Effect of Intermediate Services on the Cost of Treating Children & Adolescents with Emotional and Behavioral Problems: A Preliminary Inquiry

Authors

Introduction Methods Results Discussion References
Back to Table of Contents

Introduction

Proponents of the continuum of care treatment philosophy have argued that by expanding the array of treatment options for which insurance will pay and allowing mental health providers to use their best professional judgment to assign children to treatment cost per treated child will decline. The argument is premised on the observation that the intermediate services of the continuum of care cost less per unit than more restrictive settings (e.g., hospitals and residential treatment facilities); allowing providers to rely upon their expertise (via insurance coverage) will permit providers to substitute less expensive care that is equally, if not more, effective at ameliorating children's emotional and behavioral problems.

Return to Top

Method

Data Source and Definition of Variables

The data for this paper come from the Evaluation Sample of the Fort Bragg Evaluation Project (FBEP). The results are estimated from a sample of 982 children and adolescents for whom the first six months of treatment cost was calculated.

The service utilization of children was grouped into four categories according to the restrictiveness of services received: outpatient (OP) only, in which children received none of the new intermediate services or hospitalization/RTC treatment; intermediate non-residential (INR) care, in which the client received at least one INR service, perhaps in combination with OP therapy, but never any service in a residential setting; intermediate residential (IR) care, in which a child received at least one day of treatment in an IR facility (e.g. a therapeutic group home), perhaps in combination with hospitalization, RTC, INR, or OP therapy, but not necessarily; and, hospitalization/RTC (H/RTC) care, in which the client received at least one day of treatment in a hospital or RTC, perhaps in combination with OP therapy, but never in combination with any of the intermediate services. This serves as the dependent variable for the multinomial logit model. The other controls for the mutinomial logit and quantile regressions are listed in Table 1.

Return to Top

Results

Factors Predicting Use of Intermediate Services

One might expect that any relationship between costs and the service use categories to be a function of the severity of children's conditions. If intermediate services cost more, it may be because they are used for the children most in need of service. To account for this possibility, a multinomial logit model is estimated using the controls listed in Table 1. Indeed, based on the results of the multinomial logit model, severity is predictive across equations at both the Demonstration and Comparison sites, particularly for the IR care group. However, as may be seen in Table 2, many other factors predict use in the IR category, and very few predict for the other categories. Before one can conclude that differences in the costs at different quantiles are attributable to these severity differences, we explore the results of the quantile regressions.

Quantile Regression Estimates

Quantile regression is used to analyze cost effects because its estimates are robust to violations of the normal distribution in the dependent variable (as is frequently the case in health and mental health expenditures). The coefficients are directly interpretable as in dollars (one cannot exponentiate the marginal effects of an OLS that uses logged expenditures and get the effects in terms of dollars; see Duan, Manning, Morris & Newhouse, 1982, for why this is so), and it seems plausible that the effect of intermediate services on a child's costs will differ depending on where in the distribution that child falls.

Table 3 presents the quantile estimates for the 25th, 50th, and 75th percentiles. Quantile regression was used to estimate the effects of intermediate services for children at the 25th, 50th (median), and 75th percentiles of the cost distribution.
Important things to observe include:

- the effect of IR services increases as one moves up the cost distribution;
- at each quartile, moving a child from OP to IR would increase costs by three times what a move from OP to H/RTC would produce;
- the effect of INR approaches that of H/RTC as one moves up the distribution (i.e., INR is cheaper, but not that much cheaper);
- INR costs substantially more than OP; and
- introduction of IR and INR did lower H/RTC relative to what was experienced at the Comparison site.

Interestingly, service type rendered nearly all other controls&shyp;including previous utilization&shyp;irrelevant in explaining effects at each quantile for the Demonstration, whereas at the Comparison various diagnostic and family demographic characteristics were significant predictors of cost of the first six months of treatment.

The null finding for severity at the Demonstration in the quantile regression, coupled with the significance of severity in the multinomial logit suggest that severity influences cost through the process of sorting children into levels of care, but has no direct effect on cost otherwise.

Return to Top

Conclusion

The quantile regression estimates showed that introducing intermediate services produces different effects depending upon where in the cost distribution one lies. The increase in costs due to intermediate services are much greater than those of traditional inpatient and outpatient services.
The major limitation of these results is the ability to attribute the effects observed exclusively to the new services at the Demonstration. These results are potentially confounded with changes in cost sharing for services that were provided free of charge to families at the Demonstration. For traditional services this amounted to a price reduction of 20%; for the new intermediate services, the reduction was 100%. Thus far the Evaluation has not been able to satisfactorily separate the price effects from the service-type effects; disentangling these effects will be a major research agenda item over the next few years.
Saunders (1996) applies a three-part model similar to the model employed by Duan, et al. (1982) for the

Rand Health Insurance Experiment. However, the quantile regression results are still important because they support the conclusion that relying exclusively upon clinical wisdom as to what is appropriate treatment will not produce cost savings in addition to not producing superior mental health outcomes (Bickman, et al., 1995).

Return to Top

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Return to Top

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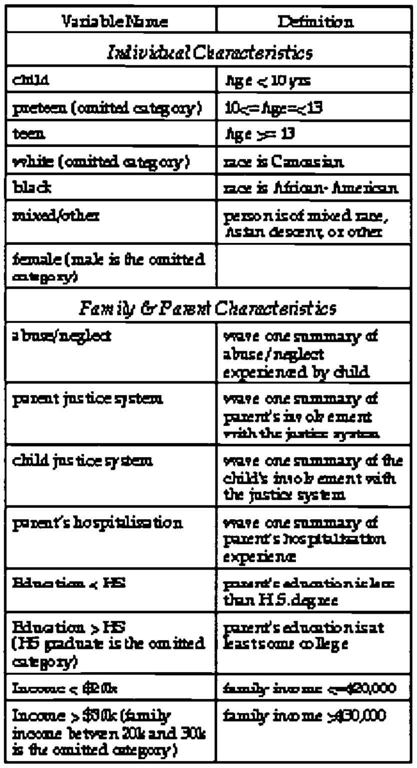
Return to Top

[Home] [Search] [Index]

Table 1

Return to Article

Variables for the Multinomial Logit and Quantile Regression Estimates



Variable Name	Definition
Individual Characteristics	
child	Age < 10 yrs
preteen (omitted category)	10<=Age=<13
teen	Age >= 13
white (omitted category)	race is Caucasian
black	race is African-American
mixed/other	person is of mixed race, Asian descent, or other
female (male is the omitted category)	
Family & Parent Characteristics	
abuse/neglect	wave one summary of abuse/neglect experienced by child
parent justice system	wave one summary of parent's involvement with the justice system
child justice system	wave one summary of the child's involvement with the justice system
parent's hospitalisation	wave one summary of parent's hospitalization experience
Education < HS	parent's education is less than H.S. degree
Education > HS (HS graduate is the omitted category)	parent's education is at least some college
Income < $20k	family income <=$20,000
Income > $30k (family income between 20k and 30k is the omitted category)	family income >$30,000

Variable Name	Definition
Severity	
Severity	composite of child psychopathology, functioning, and family's burden in dealing with the child -- standardized to mean=50, std.dev =10
Diagnosis	
Diagnosis	composite diagnostic categories based on clinician identified disorders
Missing	diagnosis is not available for the child (these cases were turned up in records review at the comparison site)
Anxiety	
ADHD	
behavioral	
mood (omitted category)	
adjustment	
substance use	
physiological	
other	
Previous Use & Timing of Use	
FY 93	enter the evaluation in FY93
FY 92 (FY91 is omitted category)	enter the evaluation in FY92
prev. use of OP svc	
prev. use of hosp/ RTC svc	
prev. multiple use of hosp/RTC	

[Home] [Search] [Index]

Table 2

Return to Article

Table 2
Factors Predicting Service Use and Direction of Effects *

		Demonstration		
INR	Mixed race	++	Severity	+
IR	Child's involvement with the justice system	++	Prior use of hospital/RTC	+++
	Household income below $20,000	+	multiple hospital/RTC visits	+++
	Severity	+++	Entering the evaluation in FY93	++
	Prior use of outpatient services	++	Entering the evaluation in FY92	+++
	Prior use of hospital/RTC	+++	Entering the evaluation in FY93	++
	multiple hospital/RTC visits	+++	Entering the evaluation in FY92	+++
H/RTC	Severity	+	Multiple prior hospital/RTC visits	+++
	Prior use of hospital/RTC	+++		
		Comparison		
H/RTC	Severity	+++	Adjustment disorder	---
	Anxiety disorder	--	Entering the evaluation in FY93	---
	ADHD	--	Entering in FY92	---

* relative to outpatient only

Note: +(-) = positive (negative) significance at .05
++(--) = positive (negative) significance at .01
+++(---) = positive (negative) significance at .001

[Home] [Search] [Index]

Table 3

Return to Article

Table 3
Quantile Regression Estimates

	25%-ile		50%-ile (Median) Regression		75%-ile Regression	
	Demonstration	Comparison	Demonstration	Comparison	Demonstration	Comparison
N=	487	360	487	360	487	360
Model fit (Pseudo R^2)	0.3478	0.2164	0.5270	0.3968	0.7108	0.5647
Quantile value	1043.65	525.00	1757.39	1472.9	8508.05	6221.5
Mean	12,398	7,393	12,398	7,393	12,398	7,393
	Coeff (Std Err)	Coeff (Std Err)	Coeff (Std Err)	Coeff (Std Err)	Coeff (Std Err)	Coeff (Std Err)
Service Type						
INR	5281.787** 335.612	—	8744.574** 330.746	—	16286.240** 471.421	--
IR	24213.910** 266.911	—	41526.110** 250.912	—	54021.340** 364.968	--
H/RTC	7659.254** 363.304	9549.495** 104.342	11951.620** 503.460	17618.020** 173.323	16906.630** 534.480	24727.040** 202.368
Severity	10.127 8.815	20.705** 4.547	13.328 8.790	33.767** 7.272	23.592 12.804	38.082** 8.710
Diagnosis						
No diag. reported	—	507.301** 131.365	—	1164.900** 215.504	—	-21.878 279.049
Anxiety	-120.222 327.299	336.970 230.446	325.360 337.641	612.324 423.777	168.878 500.296	-426.864 506.562
ADHD	96.438 232.452	223.158 151.308	-16.005 242.300	833.358* 261.022	-154.881 373.671	-666.031 340.423
Behavioral	-14.127 230.184	135.374 144.753	12.517 224.590	636.478* 249.286	-201.980 325.234	-1058.753** 317.295
Adjustment	18.990 248.682	83.187 149.235	-91.214 239.897	507.576* 249.146	18.052 388.596	-785.719* 325.101
Subst. Use	628.622 322.603	1219.549** 234.145	2707.075** 322.141	1254.626* 578.335	9790.387** 472.580	23379.79** 510.290
Physiologic	-487.268 278.752	--	-341.721 295.447	--	-585.519 454.101	--
other	1036.761 516.127	-506.577* 163.047	865.909 513.300	527.331 272.657	-11.202 749.519	-545.675 330.727

[Home] [Search] [Index]

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Do Intermediate Services Save Money? A System-Level Perspective

Authors

Introduction Methods Results Discussion References
Back to Table of Contents

Introduction

Recent changes in the delivery of mental health services to children and adolescents have been driven by the evolving notion of the continuum of care.(Stroul & Friedman, 1986). A cornerstone of such a system of care is the provision of a diverse range of mental health services. A full range of services are needed to accommodate the diversity of needs among children with emotional and behavioral disorders and their families. An added principle of the continuum of care is that when individuals are placed in services along the continuum they are placed in the least restrictive setting.
Intermediate services&shyp;both residential and non-residential&shyp;are a key component of the continuum of care. They represent services more restrictive than outpatient therapy, yet less restrictive than inpatient hospitalization or care in residential treatment centers.

An added benefit of introducing these services is that they are generally less expensive than more restrictive services. The introduction of intermediate services may improve mental health outcomes while reducing costs.

This summary examines one aspect of the introduction of intermediate services; in particular, it considers the effect on costs at the system level. The analyses are based on the experiences of the Fort Bragg Demonstration. Under this demonstration, services previously unavailable under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) were made available to military dependent children and adolescents. Known as The Fort Bragg Evaluation, the full results of this study, are reported elsewhere (Bickman, et al., 1994).

Under the Demonstration, a wide range of intermediate services were made available: in-home counseling, after-school group treatment services, day treatment services, therapeutic homes, specialized group homes and 24-hour crisis management teams. As described in Bickman, et al. (1994), the introduction of intermediate services was accompanied by other changes in the service system. Care was coordinated by treatment teams and by case managers. Perhaps most important for the study here, however, is that the Demonstration required no financial outlay for families; usual co-payments and deductibles were waived. The Demonstration was funded under a cost-reimbursement contract; therefore, (theoretically) no limits were placed on the types of services to be offered as long as they were therapeutically appropriate. The philosophy of the Demonstration called for controlling costs by providing a continuum of services designed to be appropriate for each child, rather than placing a limit (or cap) on services or cost per child. All results from the Demonstration should be interpreted in light of this fact, and we discuss the implications below.
Return to Top

Methods

The Fort Bragg Evaluation focused on a systematic comparison of care at the Demonstration site with care as usual. The latter was represented by two comparison sites, Fort Campbell and Fort Stewart. Taken together, these sites were of comparable size and had demographics similar to that for Fort Bragg. Care as usual refers to care under CHAMPUS, and coverage for mental health services under CHAMPUS is fairly generous. CHAMPUS has recently incorporated some elements of managed care. Hospital use now requires prior approval by Health Management Systems, the CHAMPUS utilization review manager. The analyses presented here focus on the utilization and cost data.

For the comparison, these data were taken from the claims from the CHAMPUS system. The claims data include information on the type of services received and on expenditures for those services. Included were any claims filed between October 1, 1990 and September 30, 1993. (Fort Campbell provided some services outside the CHAMPUS system. Service utilization records were maintained in a management information system and from there were incorporated into utilization calculations.)

Information on services received under the Demonstration was contained in a management information system. It described all services provided, including the date of service delivery, the specific service and number of units of that service received. Per-unit costs of services were calculated on the basis of budgetary information provided to the evaluation [Interested readers are referred to Bickman et al. (1994) for more details of this process].

Return to Top

Analysis

Why might one think that intermediate services would save money? Under the Demonstration, the cost of a day in intermediate residential care is 36% that of a day in an inpatient facility, while intermediate non-residential care is 50% (see Table 1). While the gap between care in a residential treatment center and intermediate services is smaller, the latter are clearly less expensive on a daily basis. This information alone, however, is not enough to guarantee that costs savings were realized. In particular, the intermediate services had to be used by significant proportions of children treated and they had to replace other, more expensive services.

If intermediate services were used by only a small percentage of all children treated, it seems unlikely that the resulting changes would be evident at the system level. The first question, therefore, involves the extent to which intermediate services were used.

Of all children treated at the Demonstration, 10.53% used intermediate services of some sort. Specifically, 5.7% of all children and adolescents treated during the Demonstration period received intermediate residential services; 8.2% received intermediate non-residential services (There was some overlap between the two; 59% of those receiving intermediate residential services received intermediate non-residential services as well). When combined, these numbers exceed the proportion of children who were hospitalized or were treated in a residential treatment center.

When used, these services involved large expenditures. The average child treated in a non-residential intermediate setting received over $17,000 worth of services in that setting during the Demonstration period. The corresponding figure for residential services is $26,835&shyp;this exceeds the figure for inpatient hospitalization.

Because significant numbers of children used intermediate services and because the expenditures involved were large, intermediate services represent a significant proportion of total expenditures at the Demonstration. Nearly 40% of total spending was on intermediate residential (19.50%) and non-residential (18.01%) services (see Table 2).

The average child treated at the Demonstration received nearly $3,000 worth of intermediate services during the Demonstration period ($1,517 and $1,401 on residential and non-residential care, respectively). When combined, these figures exceed those for residential treatment centers and inpatient facilities.

Six types of intermediate services were available: in-home services, after-school, latency partial hospitalization, day treatment, therapeutic home, and out-patient therapy. Table 3 describes the use of each type. In-home services were used most frequently&shyp;nearly half (46%) of the 638 children who received intermediate services used these services. Nearly a third of the individuals treated used day treatment. Latency partial hospitalization was the least used form of intermediate services.

The sum of the figures in Table 3 exceeds one (1.67), which implies that children who used intermediate services used more than one type. This finding was not surprising; our earlier results indicated substantial overlap between the residential and non-residential categories. In sum, significant numbers of children treated at the Demonstration used intermediate services. A large portion of expenditures at the Demonstration went to these services, and if introducing them did not reduce costs, it was not because the services were unavailable.

Whether this utilization lowered total costs, however, depended on the extent to which these services replaced other, more expensive services. As noted, a day of hospitalization was three times as expensive as a day of intermediate residential care. If, however, each day of hospitalization was replaced with 10 days of intermediate residential care, the availability of less expensive services will not reduce costs.

We examined the effect of the availability of intermediate services on total spending per client, including expenditures for hospitalization and care in residential treatment centers. Overall spending on hospitalization and on residential treatment centers was roughly 20% higher at the Demonstration site ($13,436,300) than at the Comparison sites ($11,128,290; see Table 2). To some extent, this difference reflected differences in access. A different picture emerged, therefore, when we focused on expenditures per treated child. Here, we see that expenditures on hospitalization and on residential treatment centers was actually lower at the Demonstration ($2,227 vs. $4,003).

Which perspective is valid, total expend-itures or expenditure per treated child? To the extent the availability of intermediate services lured children into the system, the added costs associated with new clients represent the costs of adding intermediate services to a system of care. On the other hand, if those costs are due solely to changes in cost-sharing requirements for parents, the reduction in the costs of hospitalization and of care in a residential treatment center per treated child may represent real savings.

Even if we suppose that the reduction in expenditures on hospitalization and on residential treatment centers is real, the reduction is not large enough to offset the spending on intermediate services. The savings on those services ($1,776) is smaller than expenditures on intermediate services ($2,917).

Return to Top

Discussion

Clearly, a day's use of intermediate services is less expensive than a day spent in a residential treatment center or in an inpatient facility. Any actual cost savings, however, depend on the way in which those services are used. This is more than a matter of sequencing (e.g., whether intermediate services are used before or after hospitalization). Rather, it is a matter of whether these services are substitutes or complements.

To see this, one should think of Rumbaugh clinic as a factory that combines different inputs into the production of good mental health. In this case, the inputs include but are not limited to mental health services (e.g., family resources can be thought of as an added input). Economists think of inputs as being either substitutes or complements. Substitutes are used to replace each other&shyp;complements improve the productivity of each other and in doing so increase the demand for each. The key is whether the use of one input increases or reduces the demand for the other.

Clearly, discussions of cost savings seem to presume that the intermediate services and hospitalization (or care in a residential treatment center) involve inputs that may be substituted one for the other. Further, it is assumed that they will be substituted at a rate less than their relative prices. If hospitalization is three times as expensive as intermediate services, then each day of hospitalization is replaced with three or fewer days of intermediate services.

It may be the case, however, that hospital-ization can be replaced only with several days of intermediate services. Indeed, intermediate services may be used as a substitute not for hospitalization but for outpatient therapy. Making intermediate services available may move individuals away from the most restrictive end of the continuum; however, it may move them away from the least restrictive end as well. The latter outcome actually may increase costs.

Another alternative is that intermediate services may not be substitutes for hospitalization at all. Rather, they may be complements&shyp;they may change the use of hospitalization and in doing so may make it more effective. Some evidence exists that this is the case. The use of hospitalization was dramatically different at the Demonstration. As discussed in Bickman et al. (1994), children hospitalized at the Demonstration left sooner but were more likely to return in the future. This change in the use of hospitalization may have been beneficial, and intermediate services may have made this possible.

What is striking about this discussion, however, is that adding more of one input (intermediate services) and improving the productivity of the other (hospitalization) implies increased production&shyp;i.e., better mental health. As discussed in Bickman et al. (1994), there is little evidence that children at the Demonstration showed greater improvement.

Several caveats are in order, however. The impetus to substitute may have been stunted by the absence of any costs savings. The very substitution assumed may depend on the presence of incentives to do so. The absence of cost-sharing not only lowers the costs of services to decisionmakers&shyp;it makes them equal and so eliminates the cost advantages associated with intermediate services.

Obversely, no reason exists to believe that incorporating cost-sharing by parents or scrutinizing spending at the Demonstration more carefully would reduce all spending proportionately &shyp;in other words, there is no reason, for example, to believe that the price elasticity of demand is equal across services. The reduction in the use of hospitalization, therefore, may have been more dramatic had parents and program administrators been faced with hard choices about how to allocate limited resources.

A second caveat involves the limited experience of mental health professionals with intermediate services. Because of this inexperience, they may have been used inefficiently. At this point, we know only that the services were used. It may be that too many people used them or too few. It may be that the wrong people used them; assigning different individuals to intermediate services may have lead to greater effectiveness. The fact that the Fort Bragg experiment was ground-breaking makes it interesting&shyp;this same fact, however, may limit the conclusions that may be drawn from it.

Savings on reduced use of hospitalization, therefore, may have been greater in a system with different financing and in a system where professionals had more experience with intermediate services. Nonetheless, intermediate services were not inexpensive. In fact, the costs savings needed to pay for those services may be greater than stated here. The Demonstration was clearly more expensive per treated child, due partially to a large increase in the use of outpatient therapy. While this difference no doubt reflects reduced cost sharing, it also may reflect the introduction of intermediate services. In particular, children treated in less restrictive environments may require more supervision in the community. Additional outpatient visits may be a requirement of increased reliance on intermediate services.

In sum, while substituting intermediate services for hospitalization offers a hope of costs savings, it is not clear that such savings were realized at Fort Bragg. It is not clear whether these savings would have been realized had different financial incentives have been in place: the lack of any cost sharing by parents may have dulled incentives to substitute intermediate services for hospitalization.
The discussion here raises clear conceptual issues. It is unclear whether hospitalization and intermediate services are substitutes or complements. It is not clear, in other words, whether intermediate services are a replacement for hospitalization or a means of making it more effective. The answer to this question&shyp;and to questions about potential costs savings&shyp;await further research on the components of care.

Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

Table 1

Return to Article

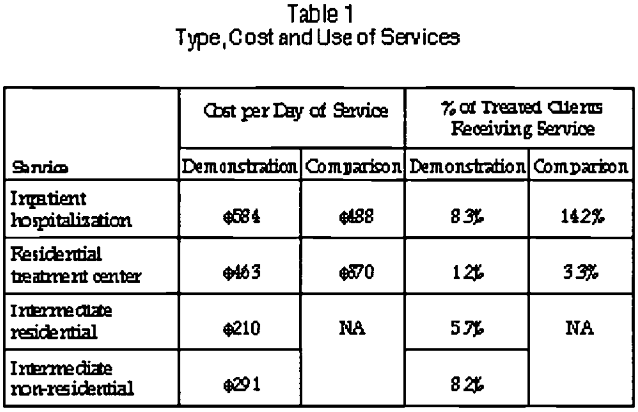

Table 1
Type, Cost and Use of Services

	Cost per Day of Service		% of Treated Clients Receiving Service	
Service	Demonstration	Comparison	Demonstration	Comparison
Inpatient hospitalization	$584	$488	8.3%	14.2%
Residential treatment center	$463	$870	1.2%	3.3%
Intermediate residential	$210	NA	5.7%	NA
Intermediate non-residential	$291		8.2%	

BEST COPY AVAILABLE

[Home] [Search] [Index]

Table 2

Return to Article

Table 2
Distribution of Costs per Treated Child for Service Types Provided

	Demonstration				Comparison			
	Total	% of Total	Per child receiving the service	Per treated child	Total	% of Total	Per child receiving the service	Per treated child
Hospital	$11,075,509	23.61	$22,107	$1,836	$6,424,653	47.12	$16,224	$2,311
RTC	$2,360,791	5.03	$33,726	$391	$4,703,437	34.50	$51,686	$1,692
Intermediate Residential	$9,150,775	19.50	$26,000	$1,597	Services not available at the Comparison sites			
Intermediate non-residential	$6,931,126	16.01	$17,073	$1,901				
Out-patient	$12,972,106	27.65	$2,471	$2,130	$1,765,325	12.95	$731	$636
Total for demonstration period*	$46,918,811	100.00		$7,777	$13,633,749	100.00		$4,904

*Total also includes case management, treatment teams, and assessments.

[Home] [Search] [Index]

Table 3

Return to Article

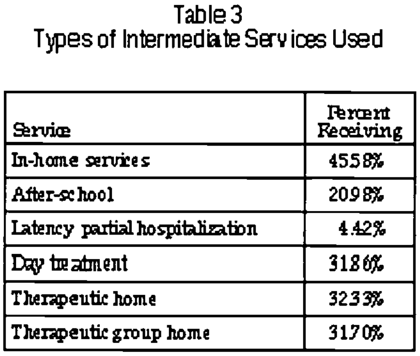

Table 3
Types of Intermediate Services Used

Service	Percent Receiving
In-home services	45.58%
After-school	20.98%
Latency partial hospitalization	4.42%
Day treatment	31.86%
Therapeutic home	32.33%
Therapeutic group home	31.70%

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

The Impact of Managed Mental Health Care on Child and Adolescent Dispositions in a Regional Emergency Mental Health Service

Authors

Introduction Methods Results References
Back to Table of Contents

Introduction

One of the primary influences in the past decade on children and adolescent mental health services has been the Child and Adolescent Service System Program (CASSP). CASSP has advocated a comprehensive system of services, organized into a coordinated network of care, that is child-centered and family-focused, with the needs of the individual dictating the services provided (Stroul & Friedman, 1986).

At the same time the clinically-oriented CASSP principles have gained widespread recognition and acceptance, the economic underpinnings of mental health services have undergone profound change. Managed care, in its various forms, is rapidly becoming the dominant mode by which mental health services are funded and coordinated.

Hypothetically, it is not difficult to imagine possibilities for both agreement and conflict between the goals of CASSP and the goals of managed care. On one hand, CASSP shares with managed care the importance that is placed on integrated and coordinated services. On the other hand, the CASSP emphasis on individual needs and flexible funds could be perceived as being in conflict with cost containment&shyp;the primary goal of managed care initiatives. Given the impact that both CASSP and managed care have had, and will continue to have, on child and adolescent mental health services, it is surprising that the relationship between these two influential movements has not been given closer empirical examination.

In this summary, we examine the relationship between some of the clinically-oriented concerns of CASSP and the economically-oriented concerns of managed care by focusing on decision-making in emergency mental health services. Because emergency mental health often occupies a central position in mental health services, it is an ideal focus for investigating systemic patterns. Referrals come from and dispositions are made to almost every other mental health service through emergency mental health. While issues of clinical decision-making for children and adolescents in acute crises have been discussed in the literature (e.g., Costello, Dulcan & Kalas, 1991; Hillard, Slomowitz & Deddens, 1988; Slagg, 1993; Way, Evans & Banks, 1992), the role of fiscal and larger systems changes in decision-making has not yet been addressed.

The Emergency Mental Health Services (EMHS) program of the University of Massachusetts Medical Center serves the entire central Massachusetts area, from New Hampshire to the Connecticut border, and includes the metropolitan Worcester area, as well as some rather rural areas of the state. EMHS is located directly adjacent to the medical emergency room. Its clients include individual adults and children who are either self-referred, referred directly from an outside agency, or who are transferred from the medical emergency room. Presenting problems range from suicidality to psychotic symptoms and other disruptions in behavior. Occasionally, clients will present with violent or self-destructive behaviors and require either chemical or physical restraint.

Clients are assessed by an EMHS clinician and an attending psychiatric resident. In some situations, a client will stabilize while at EMHS; after stabilizing, he or she is then sent home. In other cases, further intervention and treatment will be necessary.and the client will be referred to outpatient services, a community-based crisis stabilization program or will be admitted to an inpatient psychiatric setting.

Data were obtained on EMHS dispositions for children and adolescents over a 2-1/2 year interval covering the period before and after the implementation of privately managed mental health benefits for Medicaid recipients. These data allow for clarification of the contributions of clinical, economic and systems factors on decision-making and dispositional outcomes for children and adolescents in crisis.

Return to Top

Method

Data were drawn from EMHS log sheets that are completed daily and contain clinical and demographic information for all clients who receive services. Data for clients under 18 years of age were obtained for a 2-1/2 year period and divided into three different periods: the pre-managed care period (10/1/91-9/30/92); the transition period immediately following the implementation of private management of Medicaid mental health benefits (10/1/92-3/31/93); and the post-managed care period (4/1/93-3/31/94).

During these 2-1/2 years, there were 877 episodes when children were seen at EMHS. This number denotes the number of contacts or encounters and not the number of different individuals seen at EMHS. While 78% of the individuals seen at EMHS used the service only once during this period, 22% did use the service more than once, with 3% using it more than 4 times. Since repeat usage is a typical part of emergency mental health services, we believe that focusing on episodes as our unit of analysis leads to the best representation of EMHS service provision.

Encounters were pretty evenly divided between males and females, with females accounting for slightly more. Although the age of clients in these encounters ranged from 3 to 17, there was a significant skew to the right, indicating a proportionately high number of adolescents (mean ± SD = 14.3 ± -2.6; mode = 16). Fifty-seven percent of EMHS child and adolescent episodes were covered by Medicaid, 21% were covered by an HMO, 14% were covered by private indemnity insurance, and 7% were uninsured.

Of the 877 EMHS episodes included in this study, 25% resulted in inpatient admissions to either a public or a private psychiatric hospital. The largest portion of the remaining episodes (46% of the original sample) involved clients who were sent to home while the remainder went to short-term crisis stabilization, residential treatment or some other setting.

As part of our univariate analysis, we compared two different variables. First, we compared the number of EMHS episodes in the pre-managed care period and the post-managed care period in order to determine if there were differences in the volume of child and adolescent episodes. Second, we compared the proportion of EMHS dispositions to inpatient settings in the pre- and post-periods to determine if there was a change in the likelihood of children and adolescents being hospitalized.

Return to Top

Results and Implications

There was a significant increase in the number of child and adolescent EMHS episodes in the post-managed care period when compared with the pre-managed care period (episodes post, N = 393; episodes pre-, N = 297; Chi square = 13.36; $p < .001$). This is probably due, at least in part, to new regulations in the post-managed care period requiring that all Medicaid recipients referred for inpatient mental health services be screened by EMHS.

While there was an increase in the overall volume of child and adolescent episodes in the post-managed care period, there was a sharp drop in the proportion of inpatient dispositions (percent admitted to inpatient pre- = 31.7%; percent admitted to inpatient post- = 19.3%; Chi square = 14.626; $p < .001$).

This finding has both economic and clinical implications. One of the explicit goals of the move to managed care is to decrease psychiatric hospitalizations since these services are by far the most expensive in the system of care. At least in this setting, this goal is being met.

In addition to financial considerations, the CASSP principles established by Stroul and Friedman (1986) also argue that mental health treatment should be accomplished in the least restrictive setting possible. Since admissions to highly restrictive inpatient settings appear to have been diverted to less restrictive alternatives, this goal is also being realized.

The next step for our project will be to consider the role that clinical factors play in determining inpatient admission in the managed care era. One of the fears of therapists and clinically-oriented researchers concerning managed care is that clinical considerations will be replaced by decision-making that is entirely driven by finances. Our data will allow us to further explore this possibility.

Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

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The Cost of Residential Schools for Children with Severe Emotional Disturbance

Authors

Introduction Methods Results Discussion References
Back to Table of Contents

Introduction

Inpatient hospitalization for children with severe emotional disturbance (SED) is an expensive, resource-intensive treatment modality. This summary considers the costs of an alternative treatment setting, the residential school or treatment center which provides services to children with SED. The study examined the following questions: (1) What are the costs of residential schools that treat children with severe emotional disturbance? and (2) Does ownership or facility size affect the cost per child in the residential schools?

Return to Top

Methods

Data for the study came from a national, stratified sample survey of day and residential schools for children with disabilities conducted by the Department of Education in 1988. Eligible facilities included those operated by education agencies as well as other state agencies or private organizations. Facilities were selected for inclusion if one of the following criteria were met:

1. the facility identified itself as primarily treating children with SED or autism or childhood schizophrenia,
2. the facility reported that it treated a subset of children with SED, although not as their primary population treated, or
3. the facility treated children with a non-physical handicap and SED as a secondary handicapping condition (i.e., definition of a secondary handicapping condition states that the child would be classified as handicapped under the secondary condition in absence of the primary handicapping condition.).

Return to Top

Results

These residential schools represented significant expenditures on each child, although not as large as alternatives such as inpatient psychiatric hospital care, which can cost as much as $500 per day, or mental health residential treatment centers, which cost between $50,000 and $75,000 per year (Burns & Friedman, 1990).

For residential programs, the average cost per child per year was $42,215 and for facilities with both residential and day (R&D) programs, the cost per child was $47,615 for residential students and $16,962 for day students. These costs implied a 2.9 billion dollar industry. Some medical, residential and educational costs incurred by the institutions might have been paid by different agencies and were not included in these estimates; therefore, the actual size of this industry might have been larger.

The average facility size varied with type of ownership (see Table 1). Non-profit programs were smaller on average than either public or for-profit programs. For-profit schools had larger than average residential programs; 131 students on average, compared to 57 students overall in combined R&D facilities, and 110 students compared to 78 overall in residential-only facilities. Size of an institution is often considered an indicator of quality, with larger institutions offering lower quality. However, large size may also be associated with economies of scale, e.g., quality adjusted cost per case falls with the institute size. The relatively large differences in average size of the facilities by type of ownership may indicate that non-profit institutions are providing a higher level of quality. On the other hand, if there are economies of scale in terms of cost (or quality), the larger institutional size may actually indicate better economic performance.

Ordinary least squares, regressing facility characteristics on the natural log of the cost per-child were used to examine the independent effects of ownership form and facility size on cost (see Table 2). The average teacher salaries were included to control for differences in cost of doing business by state.

Ownership form did not have a significant effect on cost per-child, except for non-profit combined R&D programs. The non-profit programs were significantly more costly per child than the public programs. The coefficient on the non-profit ownership for the residential only facility was consistent with this result, but did not reach statistical significance. The number of children enrolled in the program was included to determine if there were any economies of scale. None of the coefficients on the size of the program were significant, which suggested that there were no significant economies or diseconomies of scale.

Return to Top

Conclusions

From this brief look at residential schools for children with emotional disturbances we can make several observations. Cost per child did vary by ownership form, but was statistically significant only for non-profit R & D programs relative to public facilities. Residential services offered by publicly owned R&D facilities were more expensive than either for-profit or non-profit programs. Potential reasons for this cost difference may have been the case-mix or severity of illness of children served. There also is some evidence that public programs examined may treat a different population (see Table 3). For example, public programs reported providing treatment to proportionately more children with multiple disabilities than did the others, and were more likely to report the primary disability as something other than SED.

Size of the facility did not appear to influence the cost per child. This result suggests that there are no economies or diseconomies of scale.

Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

Table 1

Return to Article

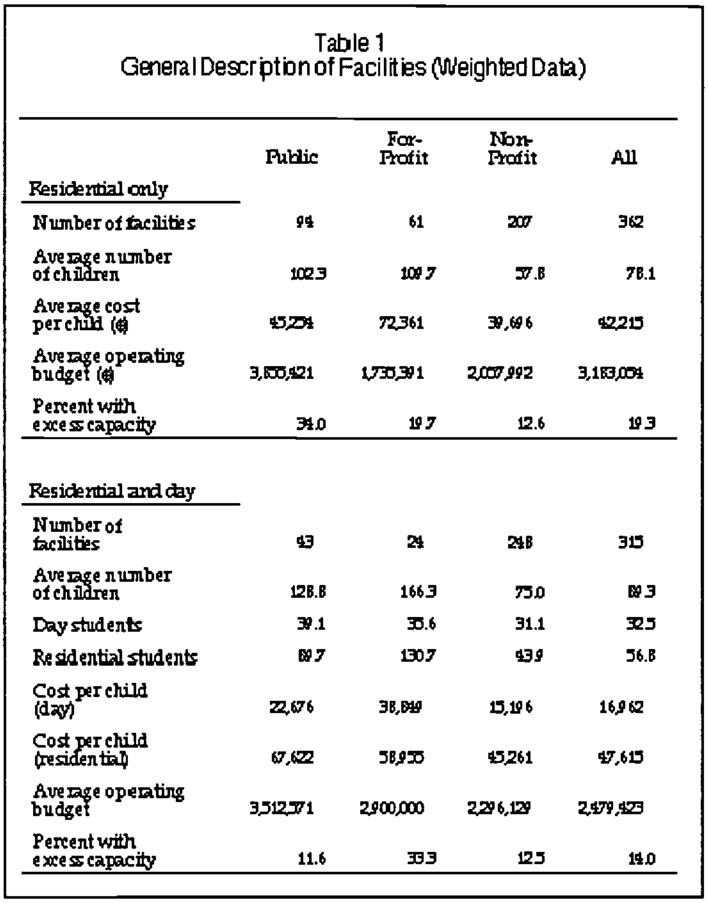

Table 1
General Description of Facilities (Weighted Data)

	Public	For-Profit	Non-Profit	All
Residential only				
Number of facilities	94	61	207	362
Average number of children	102.3	109.7	57.8	78.1
Average cost per child ($)	45,234	72,361	39,696	42,215
Average operating budget ($)	3,800,421	1,730,391	2,007,992	3,183,054
Percent with excess capacity	34.0	19.7	12.6	19.3
Residential and day				
Number of facilities	43	24	248	315
Average number of children	128.8	166.3	75.0	89.3
Day students	39.1	35.6	31.1	32.5
Residential students	89.7	130.7	43.9	56.8
Cost per child (day)	22,676	38,849	15,196	16,962
Cost per child (residential)	67,622	58,955	45,261	47,615
Average operating budget	3,512,571	2,900,000	2,296,129	2,479,423
Percent with excess capacity	11.6	33.3	12.5	14.0

[Home] [Search] [Index]

Table 2

Return to Article

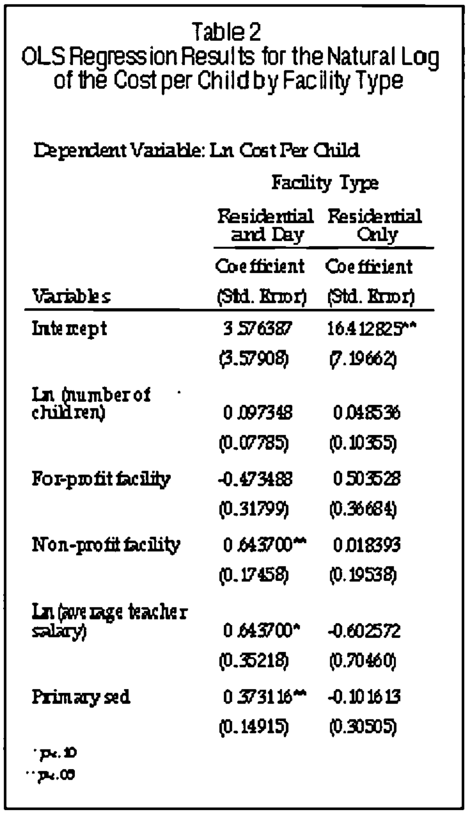

Table 2
OLS Regression Results for the Natural Log of the Cost per Child by Facility Type

Dependent Variable: Ln Cost Per Child

	Facility Type	
	Residential and Day	Residential Only
Variables	Coefficient (Std. Error)	Coefficient (Std. Error)
Intercept	3.576387	16.412825**
	(3.57908)	(7.19662)
Ln (number of children)	0.097348	0.048536
	(0.07785)	(0.10355)
For-profit facility	-0.473488	0.503528
	(0.31799)	(0.36684)
Non-profit facility	0.643700**	0.018393
	(0.17458)	(0.19538)
Ln (average teacher salary)	0.643700*	-0.602572
	(0.35218)	(0.70460)
Primary sed	0.373116**	-0.101613
	(0.14915)	(0.30505)

*p<.10
**p<.05

[Home] [Search] [Index]

Table 3

Return to Article

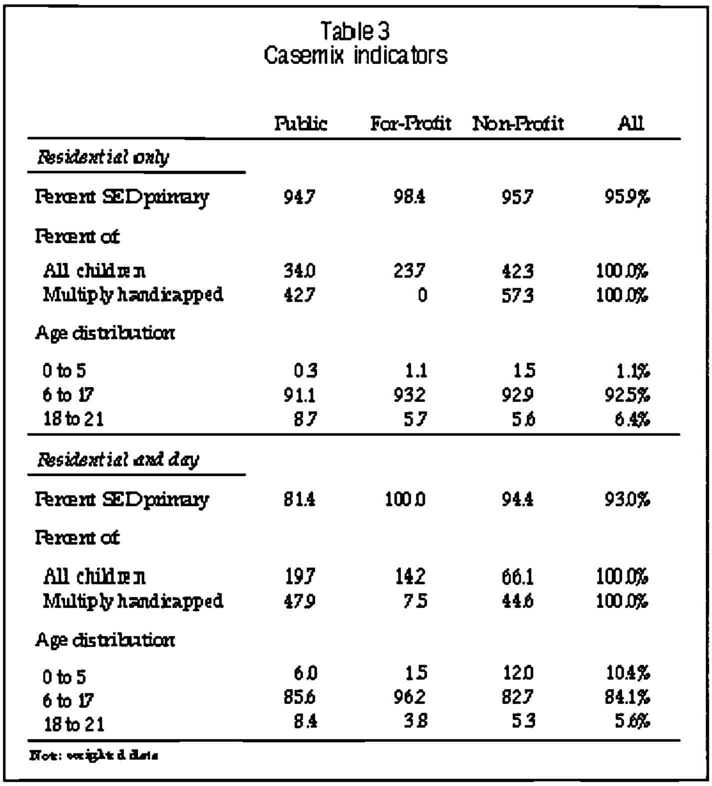

Table 3
Casemix indicators

	Public	For-Profit	Non-Profit	All
Residential only				
Percent SED primary	94.7	98.4	95.7	95.9%
Percent of				
All children	34.0	23.7	42.3	100.0%
Multiply handicapped	42.7	0	57.3	100.0%
Age distribution				
0 to 5	0.3	1.1	1.5	1.1%
6 to 17	91.1	93.2	92.9	92.5%
18 to 21	8.7	5.7	5.6	6.4%
Residential and day				
Percent SED primary	81.4	100.0	94.4	93.0%
Percent of				
All children	19.7	14.2	66.1	100.0%
Multiply handicapped	47.9	7.5	44.6	100.0%
Age distribution				
0 to 5	6.0	1.5	12.0	10.4%
6 to 17	85.6	96.2	82.7	84.1%
18 to 21	8.4	3.8	5.3	5.6%

Note: weighted data

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[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

A Comparison of Children and Adolescents Funded by Medicaid and Commercial Insurance in an Inpatient Psychiatric Facility

Authors

Introduction Methods Results Discussion
Back to Table of Contents

Introduction

As capitation becomes the norm for the provision of publicly funded mental health services, it is increasingly important to have information about different population subgroups. Capitation will require astute providers to have an understanding of the different kinds of patients and payers they are serving. This research project explores the differences between patients funded by Medicaid and patients with commercial insurance in an adolescent and child psychiatric hospital.

Return to Top

Methodology

We reviewed and selected data from the computerized client database at Cleo Wallace Center (CWC), a not-for-profit psychiatric facility for children and adolescents located in the Denver metropolitan area. Cleo Wallace Center serves 175 children and adolescents daily in three settings constituting a continuum of care&shyp;hospital, residential, and day treatment. For the purpose of this study, we selected child and adolescent patients who were discharged from the hospital program between November 1, 1993, and October 31, 1994. Patients are assigned to the child or adolescent inpatient programs based on age, diagnosis, maturity, risk factors, program design, and space availability. Typically, patients under the age of 12 are placed in the child program and patients 12 years of age and older are placed in the adolescent program. For this study we accepted the program at discharge as the delineation between child and adolescent. We extracted a total of 732 patient records with either Medicaid or a commercial insurance company as their primary payer. Individual medical records were reviewed for any data that was missing in the initial extraction.

Data was transferred from the computerized patient database to SPSS (Statistical Package for the Social Sciences) and analyzed. Key variables included length of stay in the hospital, number of re-admissions, diagnosis at discharge, gender, ethnicity, age at admission, where the patient was prior to placement, and where the patient went after treatment. For comparative purposes, only patients with an inpatient stay were reviewed.

An 18% random sample of patients was identified for each funding type (41 with Medicaid, 44 with commercial insurance). Medical record reviews were done to collect information on the number and type of previous out-of-home placements and/or psychiatric treatments and medication usage before, during, and after treatment at CWC (see Table 1).

Return to Top

Findings

Length of Stay

Patients with Medicaid funding (both adolescents and children) had longer lengths-of-stay than patients with commercial insurance (see Table 2 & Figure1).

We reviewed an additional 132 adolescent and 43 child patients&shyp; not included in the previous analysis&shyp;who had commercial insurance and moved from the inpatient program to the day hospital program. Patients with commercial insurance (both adolescents and children) who moved from the inpatient program (average LOS = 6.6 days) to the day hospital program (average LOS for adolescents is 7.3 days and for children 7.4 days) had a combined average LOS of 14 days. This was less than the average LOS for adolescents or children with Medicaid funding.

Previous Psychiatric Experience

Eighty-five patient charts were reviewed for previous psychiatric experience. Almost twice as many adolescents with Medicaid, versus adolescents with commercial insurance, had at least one previous psychiatric experience. In contrast, 54% percent of children with commercial insurance had at least one previous psychiatric experience compared to 36% of children with Medicaid.

Diagnosis at Discharge

Fifty-six percent of adolescents with Medicaid were diagnosed at discharge with a behavioral disorder compared to 35% of adolescents with commercial insurance. Fifty-five percent of adolescents with commercial insurance had an affective disorder diagnosis at discharge compared to 30% of adolescents with Medicaid funding.

About half of the children with commercial insurance or Medicaid had a behavioral disorder at discharge. However, children with commercial insurance were more likely to have an affective disorder (39%) while children with Medicaid are more likely to have an anxiety disorder (26%).

Before Placement

Adolescents with commercial insurance were twice as likely as Medicaid patients to come from a psychiatric/medical hospital or from being on-the-run prior to admission at CWC. Adolescents with Medicaid were more likely to come from an out-of-home placement (foster home, group home, residential child care facility, shelter care) or from detention/police custody.

Most children (93%) with commercial insurance came from home prior to placement at CWC. Only sixty-eight percent of children with Medicaid came from home; another 30% came from an out-of-home placement.

After Treatment

Seventy-eight percent of adolescents with commercial insurance returned home after treatment, while only 52% of Medicaid adolescents returned home. Thirty-three percent of Medicaid adolescents went to an out-of-home placement and 10% went to a more restrictive psychiatric setting like a state hospital. Only 3% of adolescents with commercial insurance moved to a more restrictive psychiatric setting. Almost all (93%) children with commercial insurance returned home. Seventy-four percent of children with Medicaid returned home after treatment, and 22% went to an out-of-home placement.

Demographics

- Average age at admission: Medicaid-funded patients discharged from the adolescent inpatient program were, on average, slightly older (15 years) than patients with commercial insurance (14.3 years). The average age for children discharged from the child inpatient program was the same (9 years).
- Adolescents were fairly evenly divided between male and female regardless of payer source. There tended to be more young male than female children regardless of payer source.
- Ethnicity: About one third of patients with Medicaid (both adolescents and children) were non-White. Twenty-two percent of adolescents with commercial insurance and 12% of children with commercial insurance were Non-white. Based on Colorado public school enrollment data, 74% of youth under 18 years of age were Caucasian and 26% were from other non-White ethnic

groups.

Medication Usage

More patients with Medicaid were using psycho-tropic drugs at the time of admission than patients with commercial insurance: 45% of adolescents and 66% of children with Medicaid; and 30% of adolescents and 56% of children with commercial insurance.

Seventy-seven percent of adolescents with Medicaid who were admitted on medications, had their medications changed while in the hospital compared to 100% of the adolescents with commercial insurance. Seventy-five percent of children with Medicaid who were admitted on medications had their medications changed while in the hospital compared to 83% of the children with commercial insurance.

More adolescents and fewer children with Medicaid funding were discharged on medications than had been admitted while on medication. More patients with commercial insurance (both adolescents and children) were discharged on medications than admitted.

Return to Top

Summary

Based on our study results, patients with Medicaid funding in a psychiatric hospital setting were different from patients with commercial insurance.

- Patients with Medicaid funding had longer lengths-of-stay, and were more likely to have been diagnosed with behavioral disorders.
- There were some race and age differences; adolescents with Medicaid funding were older, patients with Medicaid were more ethnically diverse than patients with commercial insurance.
- Patients with Medicaid funding disproportionately came from out-of-home placements (such as group homes, foster homes, etc.) and detention, while adolescents with commercial insurance were twice as likely as patients with Medicaid to come from a psychiatric/medical hospital.
- Patients (both children and adolescents) with commercial insurance returned home after treatment at a higher rate than Medicaid patients.
- Both Medicaid and commercially insured patients appeared to use inpatient services appropriately for medication evaluation and stabilization.
- Adolescents with Medicaid were more likely to have had previous psychiatric experiences than adolescents with commercial insurance. Children with commercial insurance are more likely than children with Medicaid to have had previous psychiatric treatment.

Return to Top

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Return to Top

[Home] [Search] [Index]

Table 1

Return to Article

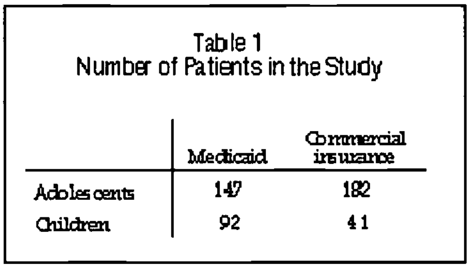

Table 1
Number of Patients in the Study

	Medicaid	Commercial insurance
Adolescents	147	182
Children	92	41

[Home] [Search] [Index]

Figure 1

Return to Article

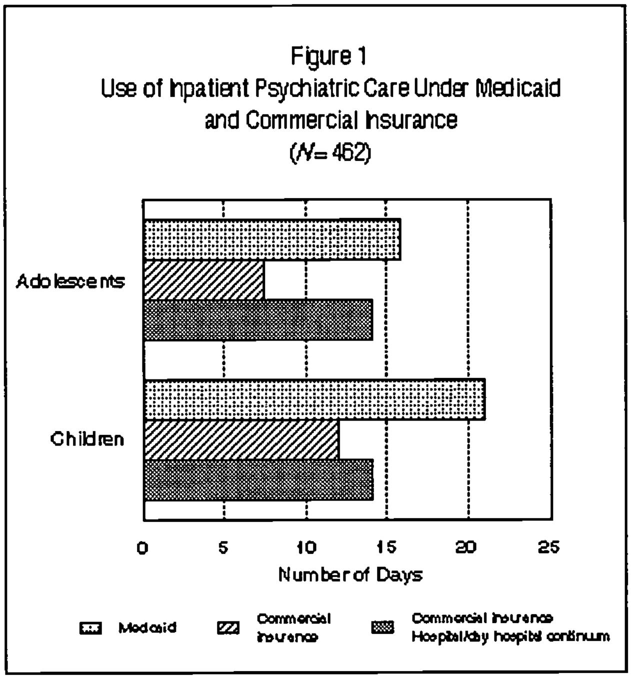

Figure 1
Use of Inpatient Psychiatric Care Under Medicaid and Commercial Insurance
(*N* = 462)

[Home] [Search] [Index]

Table 2

Return to Article

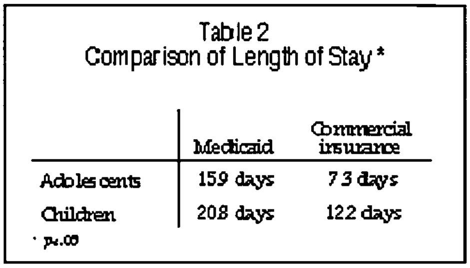

Table 2
Comparison of Length of Stay *

	Medicaid	Commercial insurance
Adolescents	15.9 days	7.3 days
Children	20.8 days	12.2 days

* p<.05

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies,
Florida Mental Health Institute, University of South Florida,1996

Measuring Satisfaction with Community-Based Services for Children with Severe Emotional Disturbances: A Comparison of Questionnaires for Children and Parents

Authors
Introduction Method Results and Implications
Return to Table of Contents

Introduction

The purpose of the present study was to investigate the psychometric characteristics of the Child and Adolescent Satisfaction Questionnaire (CASQ) and the Family Satisfaction Questionnaire (FSQ) used in the evaluation component of the Texas Children's Mental Health Plan (TCMHP). The TCMHP is an interagency public mental health initiative to provide community-based services to children and adolescents with severe emotional and behavioral problems. The current study also sought to explore the nature of children's satisfaction with mental health services.

Return to Top

Method

Instrument Development

The FSQ and CASQ were developed by a team of evaluation personnel representing the nine agencies participating in the TCMHP. Items considered for inclusion in the measure were required to capture consumer perceptions of mental health services that are important to both the consumer and the goals of the TCMHP. The fourteen items that were ultimately chosen to appear on both questionnaires are related to general satisfaction with services, consumer relationship with the service provider, consumer participation, things learned in treatment, and general child and family functioning after services. Twelve items are in the form of a 5-point likert scale, one item is a checklist of barriers, and one item provides the opportunity for written comments. Only the twelve likert scale items are scored, yielding a total score of 12 - 60.

Subjects

Consumers who were eligible to participate in the study included children with severe emotional disturbance and their families who completed TCMHP services between September 1992 and January 1994. Three hundred and fifty four parent questionnaires and 266 child questionnaires were returned. The characteristics of the children who returned the questionnaires were very similar to the total population of children served by TCMHP programs. Ninety-seven percent were between six and 18 years old. Sixty five percent were male and 36% were female. Fifty-eight percent were White, 23% were Black, 18% were Hispanic, and 2% were from other ethnic backgrounds.

Procedure

Upon completion of services, parents and children were given a copy of FSQ and CASQ and two postage paid envelopes. They were instructed to complete the questionnaires independently and return them to the research office through the mail.

Return to Top

Results and Implications

The mean FSQ score was 51 and the mean CASQ score was 50. There were no significant differences in mean satisfaction scores for variables such as ethnicity and service type for either measure. However, children and parents were more satisfied with services if the child was rated as completing services as compared to children who did not complete service. Cronbach's alpha, a measure of internal consistency, was .89 for the FSQ and .88 for the CASQ. Most items showed a moderate to high correlation with the total score for both measures.

A principal component factor analysis was performed to determine construct validity. Three factors were retained for both the FSQ and CASQ after a Promax oblique rotation was performed. Factor one, for both measures, was labeled "Treatment Effectiveness" representing high loadings for items related to treatment outcomes for the child and family, progress made in treatment, and things learned in treatment. Factor two, for both measures, was labeled "General Satisfaction" representing high loadings for items related to service provider characteristics, happiness with service, and willingness to return for services. The third factor for the FSQ was labeled "Family Participation" representing the very high loading of the family participation item. The third factor for the CASQ, labeled "Child and Provider Relationship", represented loadings of the items related to staff niceness, staff helpfulness and child participation.

The FSQ and CASQ were correlated with other measures to determine concurrent validity. The correlation between the FSQ and CASQ was moderately high. The correlation between the FSQ and ratings of the service provider's satisfaction with the case was moderate while correlations with DSM-III-R GAF scores and ratings of treatment goals met were low. The correlations between the CASQ and the same measures were also low.

The results of the study showed the FSQ and CASQ may be useful in the evaluation and monitoring of community-based mental health services. Both measures are internally consistent and seem to measure treatment effectiveness and general satisfaction with services as intended. The results also showed that children's perception of treatment outcome may be associated with the child-therapist relationship while the parent's perception of treatment outcome may be associated with general satisfaction with services. These results, taken together with the correlation of the FSQ with the service provider's satisfaction with the case, may indicate a very different experience between adults who seek and deliver services and the children who are the focus of mental health interventions.

Return to Top

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Return to Top

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Use of Consumer Satisfaction Information to Promote Change in Child/Adolescent Mental Health Settings

Authors

Introduction Methods Results Conclusions
Return to Table of Contents

Introduction

The literature on assessment of satisfaction with child and adolescent mental health services is replete with instruments to assess adolescents' and parents' satisfaction, and the beginnings of a research base on factors that influence satisfaction is developing (reviewed in Young, Nicholson & Davis, 1995). While child and adolescent mental health agencies and research projects are strongly encouraged to gather information about consumer satisfaction, there is little guidance available in the literature on how to best use this information. For example, should a certain percentage of negative responses be used as a red flag to indicate that a program has a problem, or should all negative feedback be addressed? Additionally once it is determined that there is significant dissatisfaction, how should it be addressed? Should this be a standard part of the quality improvement process, should it lead to a focused assessment, or is there some other process by which the information can be used?

The current study attempted to determine: (1) how consumer satisfaction information is most commonly obtained, (2) the purposes for gathering consumer satisfaction feedback, (3) the process for making the information useful, and (4) whether one of the barriers to utilization of consumer satisfaction feedback is the dismissal of its importance by professionals.

Return to Top

Methods

Subjects

Surveys, described below, were included in the packets of all attendees (approximately 500) of the 7th Annual Research Conference - A System of Care for Children's Mental Health: Expanding the Research Base, February 28 - March 2, 1994. This conference's participants include some of the preeminent researchers of children's mental health services, as well as service providers, administrators and consumers. Because of the low response rate, the survey was mailed to all attendees on the participant list (N=378). The total number of responses was 78.

Instrument

A written survey was developed that included a total of 9 questions, one of which contained several parts. Questions were open-ended (i.e., who provides satisfaction information?, why has consumer satisfaction been assessed?). Questions addressed characteristics of the respondent, methods used to assess satisfaction, the purpose of gathering satisfaction information and how the information had been used.

Coding

Because of the open-ended nature of the questions, answers were classified by creating categories using half of surveys, then these categories were applied to the other half of the surveys. The half on which categories were created was then coded again using the final categories to minimize drift.

Return to Top

Results

Of the 78 respondents, 83% reported that they or their organization had assessed consumer satisfaction. The largest group of respondents were those from state or local agencies (36%), followed by direct providers (23%), respondents affiliated with universities, and respondents from some other setting (19%). Thirty-six percent of respondents had developed their assessment instrument, 31% had helped collect the data, 21% had been involved in the data analysis, 18% assisted in writing up the results, 8% participated in designing the methodology, and only 12% had no direct involvement in the assessment process.

Assessment Methods

Respondents described a variety of methods for gathering satisfaction information; however, written surveys administered to both parents and children/adolescents during or after treatment was the most common method (see Table 1) Seventy-seven percent of respondents indicated that the identity of survey informants was consistently protected.

Why has satisfaction been assessed/How has it been used?

Respondents treated these two questions as the same question, indicating that the survey's intended use was the purpose for which it was gathered. Satisfaction information had been used for a variety of purposes, the most common of which was to guide program change, but also for guiding policy change, justification to funders, and adding to the literature on assessment of satisfaction.

How has satisfaction feedback lead to changes?

This question was intended to address the process by which the information lead to change. In retrospect, the question was too vaguely worded, and resulted in a reiteration of the changes that had been made rather than the process. However from the answers, it was clear that for 55% of respondents satisfaction feedback had been used to produce some specific change. Seventeen (22%) reported that the information had not been used, and another 22% described the process. In some cases, this process consisted of reporting the negative responses to boards or other groups that then decided upon action. In other cases, program directors personally contacted the respondents to address concerns not given anonymously.

What are the advantages or disadvantages of collecting or using satisfaction information?

The vast majority (81%) reported advantages of having consumer satisfaction information, the majority of which concerned matching program and policy practices with parent and consumer needs. Thirty-four percent cited disadvantages that included the labor intensity, cost of gathering the information, and the tendency of consumers/parents to rate services overly highly.

Observed negative feedback being dismissed?

Many respondents (46%) responded that they had never seen consumer feedback being dismissed, and several respondents expressed that negative feedback was the most useful kind of feedback. However, 36% reported that they had seen information dismissed. Some respondents specifically stated that parents were perceived to be part of the child's 'problem,' and their opinions were invalidated because of this. Finally, others described professionals that simply felt that it was not valid information&shyp;usually for methodological reasons.

Group Differences

Comparisons were made between the responses of those who were university, direct service, local/state agency, or other based. The only methodological difference was in the time at which satisfaction was assessed, with university-based respondents reporting more baseline assessment (57% versus 26% for direct service providers, 11% for state/local agencies and 9% for other based respondents). As one might imagine, the purposes for gathering satisfaction differed between groups, with university based respondents the only ones assessing satisfaction for research purposes (23%), while agency-based individuals were more interested in knowing the level of satisfaction with their programs (15%, versus 8% of university-based, 0% direct services, and 4% of other-based). How feedback was used also varied between groups. Ninety percent of those who were based in 'other' settings used the information to change programs (many of these were advocacy based settings). In comparison, this use was reported by 63% of direct service providers, 33% of state/local agencies and only 21% of university-based respondents. Interestingly, 20% of direct service providers used the information for policy change, as did

7% of university based respondents, while none of the state/local agency or other-based respondents reported this use.

Return to Top

Conclusions

In general, respondents were knowledgeable about procedures for assessing consumer satisfaction in the area of children's mental health. This should be considered a bias in the sample, and may not represent wide usage of consumer satisfaction assessment within children's service programs. While there was great variation in how satisfaction data was collected, there was a clear preference for written surveys assessed anonymously during and after treatment. It is encouraging that satisfaction was frequently, and equally, assessed for both parents and children/adolescents.

The purpose and use of having consumer satisfaction feedback was varied and interesting. The primary purpose was reported to be to inform and improve services. Although the details of these service changes were not often presented, many respondents did report some changes being made in response to satisfaction data. At the same time, dismissal of negative consumer feedback was not uncommon. There were also clear differences in the reasons for collecting this type of data across the different service settings of the respondents. Lastly, the survey was not adequately constructed to assess the process by which satisfaction information leads to change.

In our review of the consumer satisfaction literature (Young, et al., 1995), we found that procedures for utilizing consumer satisfaction feedback for programmatic or policy change were not addressed. With the current ubiquitous demand to obtain consumer satisfaction information, and the desire of policy makers, administrators and providers to know what is satisfying and dissatisfying about their services, it is important that concrete procedures to respond to consumer feedback be described and discussed in the future.

Return to Top

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Return to Top

[Home] [Search] [Index]

Table 1

Return to Article

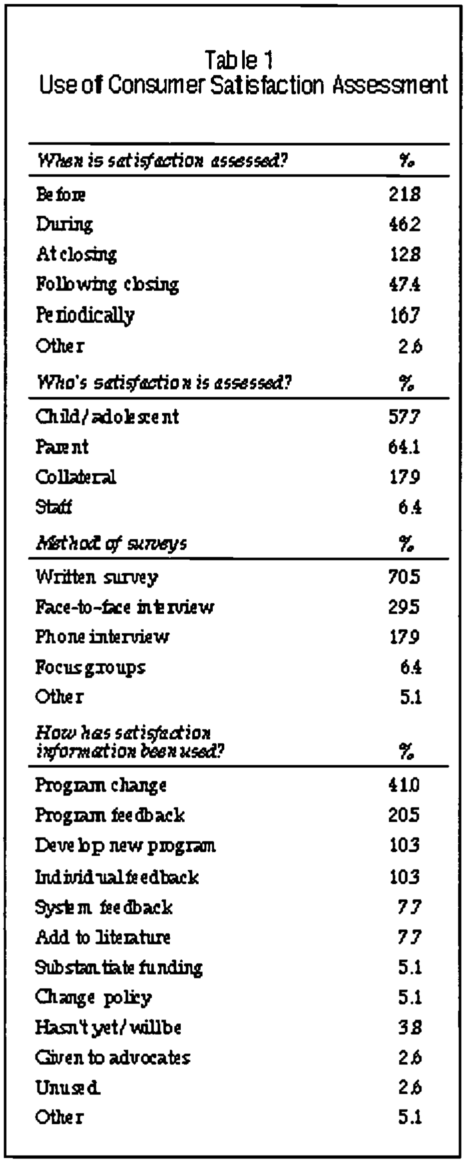

Table 1
Use of Consumer Satisfaction Assessment

When is satisfaction assessed?	%
Before	218
During	462
At closing	128
Following closing	47.4
Periodically	167
Other	2.6
Who's satisfaction is assessed?	%
Child/adolescent	577
Parent	64.1
Collateral	179
Staff	6.4
Method of surveys	%
Written survey	705
Face-to-face interview	295
Phone interview	179
Focus groups	6.4
Other	5.1
How has satisfaction information been used?	%
Program change	410
Program feedback	205
Develop new program	103
Individual feedback	103
System feedback	77
Add to literature	77
Substantiate funding	5.1
Change policy	5.1
Hasn't yet/will be	38
Given to advocates	2.6
Unused	2.6
Other	5.1

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida, 1996

Parent Satisfaction with Mental Health Staff Interactions: The Development,Validity, and Reliability of the Parent Satisfaction Scale and the Parent-Staff Interaction Scale

Authors
Purpose Methodology Findings References
Return to Table of Contents

Purpose

It has been conservatively estimated that 12% or 7.5 million of the nation's children suffer from mental health problems (National Institute of Medicine, 1989; U.S. Department of Health and Human Services, 1990). Approximately 2 million of these children have received treatment, and about half of those receiving treatment have been getting inappropriate treatment (Saxe, Cross & Silverman, 1988). Services for these children have been described as fragmented, duplicated, and too restrictive (Knitzer, 1982; Young, 1990). Services have also been criticized for not being community based, for being driven by the needs of the providers or payers rather than the needs of the children and their families, and for failing to include parents as part of the treatment team.

The need exists to assure that appropriate treatment is available to children with mental health problems and to their families. An important part of this assurance is obtaining parent satisfaction information. Parent satisfaction scales are needed that are: (a) valid and reliable; (b) specific enough for meaningful interpretation (versus general, global statements); (c) based upon models with well-defined concepts; (d) actually measuring the concept, satisfaction; and (e) able to allow comparisons across studies and settings.

The Parent Satisfaction Scale (PSS) and the Parent-Staff Interactions Scale (P-SIS), developed to address these needs, measure parents' perceptions of mental health staff providing services to their children. The PSS is made up of direct measures of parents' satisfaction with staff interactions. The P-SIS consists of parents' perceptions of staff interactions. The purpose of this summary is to describe the development, validity, and reliability of the PSS and P-SIS.

Return to Top

Methodology

Instrument Development
The literature related to consumer satisfaction and to mental health service delivery to children was reviewed, along with existing consumer and parent satisfaction scales, to identify items for the P-SIS. A total of 76 items were generated. Several conceptual sub-scales were identified, including staff attitudes, staff availability, informing parents, providing support, including parents, and staff helpfulness.

Content and Face Validity
Prior to content and face validity efforts, the 15 items in the conceptual subscale Helpfulness were deleted, as Lebow (1982) suggested, to avoid using outcomes from treatment as part of a satisfaction scale. The remaining 61 items were shared with two parents of children with mental health problems who were also directors of state-wide parent networks. They were asked to rate the items on a 4-point scale from extremely relevant to not relevant; to identify any content areas not included; and to make recommendations about the wording of items. Neither parent completed the rating scale, but did provide

face validity by making suggestions for additional items and wording changes.

The items were also given to five professional experts in children's mental health and/or consumer satisfaction research. An 80% item support criterion was set to retain an item. All items except two met this criteria. With recommendations for wording changes, these two items were reworded and retained. This process established content validity. A total of 12 new items were recommended by the parents and professionals and added to the scale. With consultation from two doctorally-prepared experts in instrument development, the Helpfulness items were returned to the P-SIS because they appeared to be clear measures of parents' perceptions of how staff interacted with them. The P-SIS had 88 items.

It was anticipated that the more positively parents perceived their experience with staff, the more positively they would rate their satisfaction with staff interactions. The 19 item PSS was developed by compiling direct questions about parent satisfaction for each of the conceptually derived P-SIS subscales along with an overall statement of satisfaction with staff to provide construct validity. Two independent items expected to be positively related to the P-SIS were also added for criterion validity including: a) If I needed services for my child again, I would go back to these staff; and b) I would recommend these staff to friends and neighbors with similar problems. All of the items were rated on a 5-point Likert type scale from strongly agree to strongly disagree.

Sample
In the first of three waves of testing, the P-SIS (88 items) and the PSS (19 items) were tested with a convenience sample of Indiana support group members with 44 scales completed. After scale revision, the P-SIS (36 items) and the PSS (12 items) were tested with a convenience sample of parents of children discharged from a state, in-patient program, resulting in 24 completed scales. After further revision, the P-SIS (13 items) and the PSS (7 items) were distributed to 160 parents of students with mental health problems (in process at the time of this summary).

Scale Revision
The majority of items were deleted due to inter-item correlations above .70, indicating redundancy, with only a couple items deleted due to correlations below .30. The item-total correlation, alpha if deleted, judgment of conceptual desirability, variance, and mean were used to further determine which of the highly correlated items to remove.

To retain an item, it needed to have a high correlation to the total number of items, the alpha if deleted needed to be a significant decrease, the variance needed to be broad enough to show it was sensitive in discriminating the differences among individuals, and/or the mean needed to be relatively close to the midpoint of 3 to limit the positive skew seen in most satisfaction and perception scales (Lebow, 1982).

Return to Top

Findings

Reliability and Criterion Related Validity
A high inter-item correlation indicated high internal consistency and provided evidence for both scales' reliability with the alpha for both the P-SIS and the PSS being .98 (N=68). Criterion related validity was evident with the correlation of the P-SIS to independent would return and would refer items of .88 and .87, respectively (N=68). Further, the P-SIS was strongly correlated with the PSS (r=.98).

Discussion
The P-SIS and PSS were developed in response to the need to have parent satisfaction instruments with strong psychometric support for use in evaluating parents' satisfaction with services for their children with mental health problems. Validity and reliability of the P-SIS and the PSS were supported. The P-SIS and PSS, having been drawn from a large pool of items, provide specific enough information about parents' perceptions of staff interactions to be meaningful. Clustering of the item means around the mid-point of the 5-point Likert scale and broad standard deviations indicate that the scales capture variability between subjects and do not have the usual positively skewed results seen in most satisfaction measures. These scales should prove useful in gaining information about parents'

satisfaction with and perceptions of staff interactions.

Return to Top

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Return to Top

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Return to top

[Home] [Search] [Index]

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Measuring Perceptions of Family Involvement in Service Provision for Youth with Serious Emotional Disturbance

Authors

Introduction Method Results Discussion References
Return to Table of Contents

Introduction

Family involvement in the provision of services for youth with serious emotional disturbance (SED) is an important correlate of family empowerment and provides an index of the service delivery system's responsiveness to the needs of families (Able-Boone, Sandall, Loughry, & Frederick, 1990; Collins & Collins, 1990; Dunst & Trivette, 1988; Zimmerman & Rappaport, 1988). Recent empirical work investigating the components of collaboration between parents and mental health professionals revealed family involvement to be of paramount importance in a successful collaborative relationship between parents and professionals (DeChillo, Koren, & Schultze, 1994). Various components of family involvement have been identified in the context of mental health service delivery, including: (a) the continuous involvement of the family in services, (b) appropriate education of the family about services, (c) involvement of the family in all decisions related to treatment, (d) encouraging the family to participate in all phases of the treatment process, and (e) keeping the family updated and informed on the process and progress of treatment (Able-Boone et al., 1990; Brotherson & Goldstein, 1992; Collins & Collins, 1990; Goodman & Hover, 1992).

There is currently no simple, valid, and reliable rating scale that can be used to measure family involvement in the provision of mental health services. Given the importance of family involvement in the provision of services, its measurement and quantification would be a useful step in understanding the nature of the interplay between parents of children with SED and service providers. To this end, the current study examined the psychometric properties of a rating scale designed to measure perceptions of family involvement. The rationale for the scale was based on the concept of empowerment and the assumption that family involvement is intimately linked to empowerment, with more empowered families exhibiting greater involvement in the design and delivery of services for their children with disabilities (Koren, DeChillo, & Friesen, 1992; Singh et al., 1995).

Return to Top

Method

Scale Development

The initial pool of items was obtained through the critical incident method by asking families in focus groups what issues were important to them in the design and delivery of treatment services. These issues were phrased as individual items that could be rated on a Likert scale. Further items were generated that were commensurate with the general orientation of family involvement in the assessment, planning, and treatment of youth with SED. These items were then inspected for conceptual overlap, clarity, and face validity. Thirty items were retained for the final rating scale, with a 5-point Likert rating (1 = strongly disagree to 5 = strongly agree). Two parallel versions of the scale were developed: Perceptions of Family Involvement: Family Version and Perceptions of Family Involvement: Professional Version. The content of the items is identical between the two forms, while the wording of the items is appropriate for parents or professionals.

Participants

The Perceptions of Family Involvement: Family Version was completed by 225 parents of children with SED and/or ADHD. Approximately 88% of the parents were mothers, 77% were Caucasian, and 17% were African-American. Most of the identified children were boys (71%), and 61% of the respondents were married. Respondents were evenly distributed among educational and income levels. The mean age of the parents was 41.5 (SD = 8.6) years, and the mean age of the identified child was 13.8 (SD = 4.4) years.

The Perceptions of Family Involvement: Professional Version was completed by 264 mental health professionals. Approximately 40% of the professionals were men, 91% were Caucasian and 5% were African-American, and a majority identified themselves as either counselors or social workers. The modal professional had worked for 11 to 15 years with youths identified as having SED . The mean age of the professionals was 41.1 (SD = 9.1) years.

Procedure

The Perceptions of Family Involvement: Family Version was mailed to a sample of parents of children with SED. Parents completed the rating scale and a cover sheet which solicited demographic information. The Perceptions of Family Involvement: Professional Version was mailed to a national sample of mental health professionals who work with children with SED and their families. Professionals completed the rating scale as well as a cover sheet with demographic information.

Return to Top

Results

A factor analysis of both versions of the Family Involvement Scale was undertaken to determine the underlying factor structure and the psychometric properties of the scales. A principal components procedure was used for the extraction of factors, with unity (1's) on the diagonal of the correlation matrix for deriving the initial estimates of communality. A varimax (orthogonal) rotation was used to obtain the rotated factor structures. Determination of the number of factors was guided by both statistical and conceptual approaches. Rather than strictly adhering to the eigen value greater than one rule or some other solely mathematical approach for determination of the number of factors to retain (Zwick & Velicer, 1986), solutions of various numbers of factors were examined with the following questions in mind: (a) did each factor make sense conceptually?; (b) was each factor a logical component of the concept of family involvement?; (c) did each factor appear unidimensional without being trivial?; (d) was the solution as a whole a parsimonious representation of family involvement?; and (e) did the factor structure have robust statistical properties?

Perceptions of Family Involvement:
Family Version

Three- and four-factor solutions of this version were the most conceptually meaningful and statistically sound. Inspection of the scree plot (Cattell, 1978) and the coefficient alpha reliabilities indicated that either of these solutions would be statistically acceptable. However, the fourth factor of the four-factor solution contained three items that did not appear to fit together conceptually. In the three-factor solution two items (17 and 18) did not have a statistically significant loading on any of the factors. The resulting three-factor solution without items 17 and 18 in the analysis was determined to be the most conceptually meaningful and statistically robust.

The three factors together accounted for 66.4% of the total variance. Table 1 presents relevant statistical properties of the factors and their coefficient alpha internal reliabilities. A factor loading of at least 0.40 was used as the cut-off for a significant factor loading of an item. All but two of the items (17 and 18) loaded on at least one factor, and 12 items loaded significantly on two factors. The mean factor loadings for items on Factors I, II, and III were 0.69, 0.63, and 0.67, respectively.

Factor I (Treatment) consisted of 14 items that generally represented family involvement in direct treatment services, including items about treatment satisfaction, follow-up, and treatment planning.

Factor II (Parent-Professional Partnership) consisted of seven items that represented decision making and planning about treatment as well as assessment in partnership with the family. Factor III (Information/Courtesy) consisted of seven items that represented keeping the family informed about the child's treatment, and showing respect and courtesy to the family in the treatment process.

The Guttman split-half estimate of reliability was 0.91 for the final scale. The alpha coefficients for the factors are shown in Table 1. These internal reliability coefficients are large, and indicate substantial internal consistency (DeVellis, 1991). Table 2 presents the Pearson correlations among the factors. The magnitudes of the correlation coefficients are moderately high and all are significant at the $p<0.001$ level. These correlations would suggest that the three components of family involvement revealed by the factor analysis are interdependent.

Perceptions of Family Involvement: Professional Version

A five-factor solution of this scale was the most conceptually clear and statistically robust solution. Although Factor V contained only two items, these items loaded together on one factor regardless of the solution examined and it was felt that together they represented a conceptually valid factor. The statistical properties of these factors are shown in Table 3. The five factors together accounted for 61.9% of the total variance. Again, a factor loading of at least 0.40 was used as the cut-off for a significant factor loading of an item. All of the items loaded significantly on unique factors. The mean factor loadings for items on Factors I, II, III, IV, and V were 0.63, 0.65, 0.63, 0.70, and 0.75 respectively.

Factor I (Treatment Planning) consisted of 10 items that represented family involvement in treatment planning, including items about involvement in treatment planning meetings and formulation of a treatment plan. Factor II (Follow-Up) consisted of eight items that addressed issues concerning follow-up after treatment has been completed. Factor III (Decision-Making) included six items that represented family involvement in decisions about meetings, assessment, and the types of services to be provided. Factor IV (Assessment) consisted of four items concerning family involvement in the assessment process. Factor V (Global Involvement) consisted of two global items that concerned family involvement in treatment.

The Guttman split-half estimate of reliability was 0.85 for the entire scale. The alpha internal reliability coefficients for the five factors are shown in Table 3. These coefficients are large, and indicate substantial internal consistency (DeVellis, 1991). Table 4 presents the Pearson correlations among the five factors. The magnitudes of the correlation coefficients were moderately high, with the exception of the correlations of Factor V with the other factors, and all are significant at the $p<0.05$ level. These correlations would suggest that four of the components of family involvement revealed by the factor analysis are interdependent, while the Global Involvement factor only weakly correlates with the other four factors.

Return to Top

Implications

The results of the factor analyses of the parallel forms of the Family Involvement Scale indicate that the concept of family involvement is a valid construct, and the instrument devised to measure it has robust psychometric properties. The two forms of the scale yielded somewhat different factor structures. The factors of the professional version paralleled the service delivery process more closely than the factors from the family version, which were more global. This is perhaps reflective of differences between professionals and families in the level of knowledge and perception of the mental health service delivery system. These scales will provide a useful tool for service providers wanting to assess the level of family involvement in services. Utilizing both forms will reveal discrepancies between professionals' and families' perceptions of family involvement, and will reveal areas where families perceive deficiencies in their involvement in services.

Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

Table 1

Return to Article

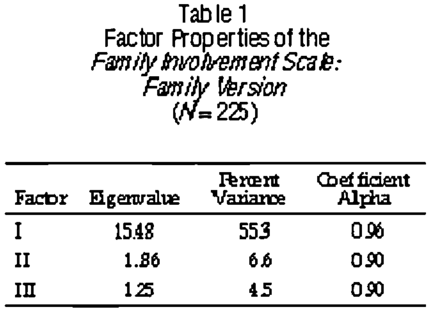

Table 1
Factor Properties of the
Family Involvement Scale: Family Version
(N = 225)

Factor	Eigenvalue	Percent Variance	Coefficient Alpha
I	15.48	55.3	0.96
II	1.86	6.6	0.90
III	1.25	4.5	0.90

Table 2

Return to Article

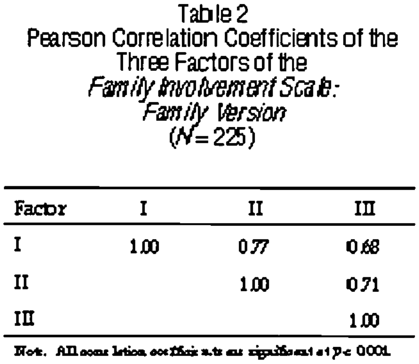

Table 2
Pearson Correlation Coefficients of the Three Factors of the *Family Involvement Scale: Family Version*
(*N* = 225)

Factor	I	II	III
I	1.00	0.77	0.68
II		1.00	0.71
III			1.00

Note. All correlation coefficients are significant at $p < .0001$.

[Home] [Search] [Index]

Table 3

Return to Article

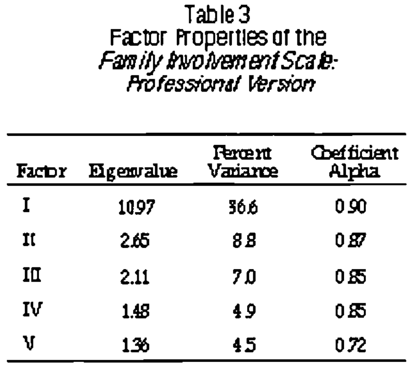

Table 3
Factor Properties of the
Family Involvement Scale:
Professional Version

Factor	Eigenvalue	Percent Variance	Coefficient Alpha
I	10.97	36.6	0.90
II	2.65	8.8	0.87
III	2.11	7.0	0.85
IV	1.48	4.9	0.85
V	1.36	4.5	0.72

[Home] [Search] [Index]

Table 4

Return to Article

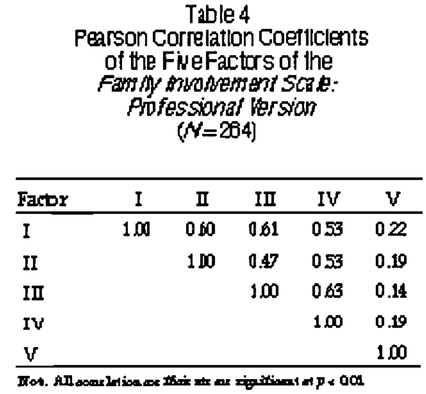

Table 4
Pearson Correlation Coefficients
of the Five Factors of the
Family Involvement Scale:
Professional Version
($N = 264$)

Factor	I	II	III	IV	V
I	1.00	0.60	0.61	0.53	0.22
II		1.00	0.47	0.53	0.19
III			1.00	0.63	0.14
IV				1.00	0.19
V					1.00

Note. All correlation coefficients are significant at $p < .001$

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida, 1996

Families' Perception of the Effects of Respite

Authors

Introduction Method Results Discussion References
Return to Table of Contents

Introduction

Respite care is the formal mechanism for providing short-term care to children with disabilities to provide relief to parents or other caregivers from the stress of child care. Respite care represents one highly effective mechanism in achieving the mission and policy of public mental health systems to reduce the consequences (frequency and intensity) of disability, impairment, disturbance, or illness for children, their families and their communities. Its beneficial effect on family functioning and crucial role in preserving families is well documented. It should be a prominent element in achieving the mission and policy of public mental health systems as they shift from institutionally based, pathologically focused, and professionally driven paradigms to community based, strength focused, consumer driven paradigms.

Families report respite care to be an important source of support in their efforts to raise their children with special needs. The effects that families experience when using respite care are not uniform. This paper will examine the relationship among parents' perceptions of the impact of respite care, their level of social support, and intra-family resources' (money and time) availability on their stress.

Return to Top

Method

Procedures

A total of 319 families out of 889 families (35.9%) at nine county-based community mental health programs volunteered for the study. Interviews were conducted by telephone using trained interviewers and computer assisted interviewing technology with 162 randomly selected families. A follow-up survey was mailed to each parent who was interviewed with 150 returning the survey. This follow-up survey contained Friedrich's (1983) Short-form of the Questionnaire on Resources and Stress (52 items), Dunst's (1988) Family Support Scale (19 items), and Family Resource Scale (31 items).

The majority of families were white and had an average income between $20,000 and $29,999 (see Table 1). Respondents were primarily female, i.e., mothers, with an average age of 44.13 years (SD = 13.31) and had completed high school or more schooling (89.5%). The largest percentage of respondents did not work outside of the home. Two-thirds of the interviewed families were two parent families. When compared to the service population of 889 families, the 162 interviewed families were not statistically significantly different in terms of ethnicity but did have higher income levels.

The average age of the children (which included adult children) was 16.82 years (SD = 12.70). Slightly more than half the children were male (see Table 2). Mental retardation was the most frequent primary diagnosis. The extent to which children's disabilities affected their functioning is presented in Table 3. Mental development, physical mobility, and ability to communicate were rated by the parents as somewhat to greatly affecting functioning. Parents assessed their children's need for assistance with every day activities as nearly total. They indicated that their children required specialized medical care several times per month and had major behavior problems at least once a week, on average.

Analysis
Eight variables were selected to represent the major conceptual domains of a stress adaptation model (Singer & Irvin, 1991; Wikler, 1986) in the path analysis (see Figure 1). Seven of these domains served as independent variables: (1) presence of a spouse (0 = no, 1 = yes); (2) amount of care required by the child, calculated by summing the scores on the six functioning variables (a = .61); (3) perceived helpfulness of the parent's social support network as measured by the total scale score on the Family Support Scale low score = not helpful, high score = extremely helpful, a = .80). Intervening variables were: (4) adequacy of money resources measured by the mean score on seven items from the Family Resource Scale related to money (a = .90, 1 = not adequate and 5 = always adequate); (5) frequency of use of respite care during the last six months measured on a five-point item as part of the telephone interview (1 = not used, 2 = less than once per month, 3 = 1 to 3 times per month, 4 = once a week, 5 = more than once a week; (6) parent's perception of the adequacy of relief from childcare measured using one item from the Family Resource Scale that ask about the adequacy of baby sitting (1 = not adequate, 5 = always adequate); (7) perception of the adequacy of time resources measured by the mean score on nine items from the Family Resource Scale related to time (a= .86, 1 = not adequate and 5 = always adequate). The dependent variable was (8) parental perception of stress as measured by the Questionnaire on Resources and Stress (QRS-F). Total scale score was used (a = .92) where a low score indicated low stress and a high score indicated high stress. Mean scores for these variables are presented in Table 4.
Return to Top

Results

Bivariate Analysis
Use of respite was negatively correlated (-.25) with adequacy of money resources and with the adequacy of time resources (-.24). This suggests that families with better financial situations are less likely to obtain childcare from public services. The use of respite care was positively correlated (.24) with stress. These observations indicate the need to understand the combination effects of other variables with the use of respite on perception of stress.

Path Analysis
The hypothesized path flow is depicted in Figure 1 and includes the significant bivariate relationships. Multiple regression analyses were conducted regressing each variable on all variables preceding it in the model. Figure 2 displays the relationships among the variables with significant betas ($p < .05$). The path flow shows the amount of respite received increased as the child's disability became more severe and decreased as the adequacy of money resources increased. The child's disability level affected perception of the adequacy of time resources directly, with time decreasing and stress increasing as level of disability increased. Disability level had an indirect effect on adequacy of time resources through adequacy of money resources (Variable 4, indirect effect = -.11), which acted as a moderator variable on time resources. The child's disability level also had a direct effect on stress, increasing stress as disability level increased, and a strong indirect effect via perception of time resources (Variable 7, indirect effect = .19) decreasing the adequacy of time resources. The presence of a spouse only indirectly affected stress level, with the strongest path via adequacy of money and time resources. Helpfulness of the social support network had virtually no effect on perception of stress.

The amount of respite care and adequacy of baby sitting has only indirect effects on perception of stress. For both variables, this effect was via the effect on time resources. The adequacy of money resources was negatively related to respite but positive related to adequacy of baby sitting. This suggests that while better financial situations resulted in less publicly supported childcare, it was balance by the ability to purchase or find childcare from other sources. The indirect effect of respite care is small (-.03) while the indirect effect of adequacy of baby sitting is much stronger (.12). For both variables, positive changes result in decreased stress by improving the parent's perception of time resources.
Return to Top

Conclusions

The path analysis demonstrated the complex set of relationships that control the effective impact of respite care on parental perception of stress. One of the outcomes expected for respite care is a reduction in stress. This analysis suggests that respite care indirectly reduces stress by affecting the availability of personal time for the parent. Not surprisingly, the child's level of disability was found to be a dominant factor, directly and indirectly moderating the affects of time and money resources and respite care. When the relationship between respite care and parental perception of stress was viewed independent of other variables, respite care did not appear to have a positive impact. However, when the relationship of respite care to stress is viewed with the context of other variables (e.g., the child's level of disability, adequacy of monetary resources, and the adequacy of baby sitting), its positive effects on parental perception of time resources and through time on stress become evident.

The role of monetary resources and its interaction with the use of respite care was also evident in the path model. This model suggests that public programs can affect the amount of stress experienced by parents by providing respite care. However, in the amount provided by typical programs, respite care is likely to have only a marginal effect on stress. Adding money resources to the family system as through cash subsidy program is likely to have a greater impact on stress levels. These analyses suggest that a combination of respite care and cash subsidies may be a stronger intervention than either alone.

The strong role of time adequacy in relationship to parental stress also suggests that interventions with families need to assess parent's perceptions of time for themselves and provide supports that increase the time and opportunities parents have to care for themselves. Respite care clearly has the potential to do this but will need to be matched to parents' personal level of need as well as the child's needs.

Return to Top

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Return to Top

[Home] [Search] [Index]

Table 1

Return to Article

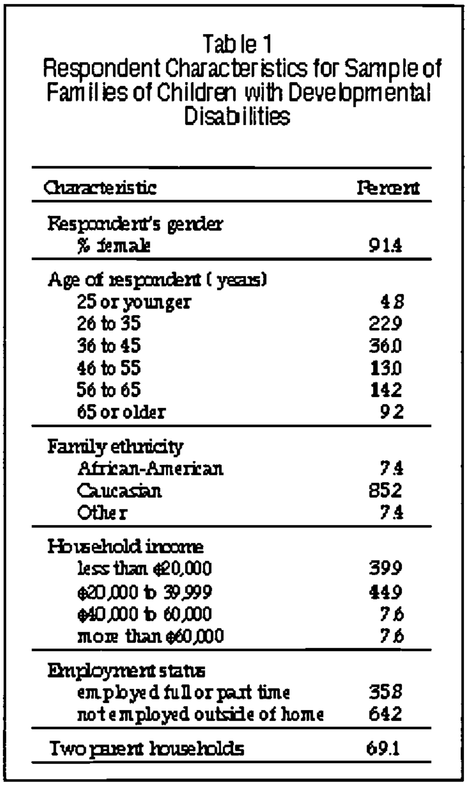


Table 1
Respondent Characteristics for Sample of Families of Children with Developmental Disabilities

Characteristic	Percent
Respondent's gender	
% female	91.4
Age of respondent (years)	
25 or younger	4.8
26 to 35	22.9
36 to 45	36.0
46 to 55	13.0
56 to 65	14.2
65 or older	9.2
Family ethnicity	
African-American	7.4
Caucasian	85.2
Other	7.4
Household income	
less than $20,000	39.9
$20,000 to 39,999	44.9
$40,000 to 60,000	7.6
more than $60,000	7.6
Employment status	
employed full or part time	35.8
not employed outside of home	64.2
Two parent households	69.1

[Home] [Search] [Index]

Table 2

Return to Article

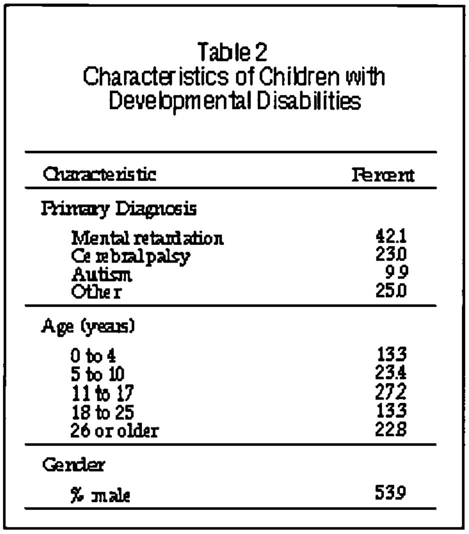


Table 2
Characteristics of Children with Developmental Disabilities

Characteristic	Percent
Primary Diagnosis	
Mental retardation	42.1
Cerebral palsy	23.0
Autism	9.9
Other	25.0
Age (years)	
0 to 4	13.3
5 to 10	23.4
11 to 17	27.2
18 to 25	13.3
26 or older	22.8
Gender	
% male	53.9

[Home] [Search] [Index]

Table 3

Return to Article

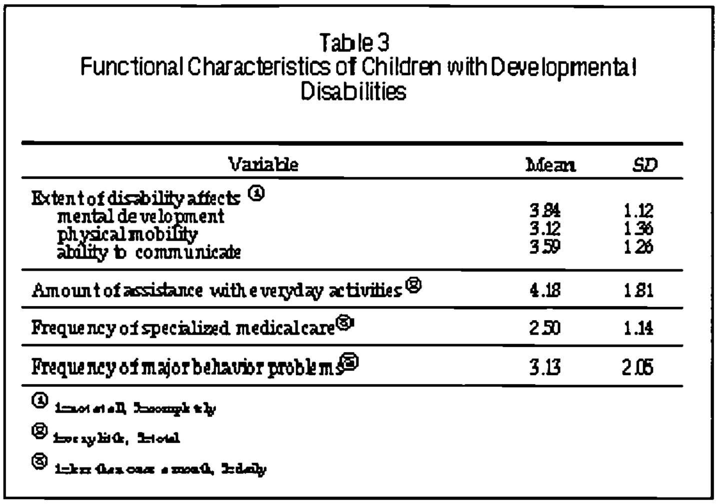


Table 3
Functional Characteristics of Children with Developmental Disabilities

Variable	Mean	*SD*
Extent of disability affects ①		
mental development	3.84	1.12
physical mobility	3.12	1.36
ability to communicate	3.59	1.26
Amount of assistance with everyday activities ②	4.18	1.81
Frequency of specialized medical care ③	2.50	1.14
Frequency of major behavior problems ③	3.13	2.05

① 1=not at all, 5=completely

② 1=very little, 5=total

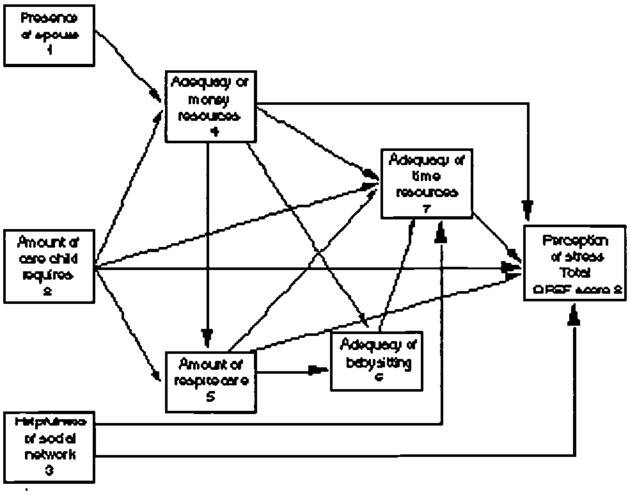
③ 1=less than once a month, 5=daily

[Home] [Search] [Index]

Figure 1

Return to Article

Figure 1
Hypothesized Path Flow Chart



BEST COPY AVAILABLE

[Home] [Search] [Index]

Table 4

Return to Article

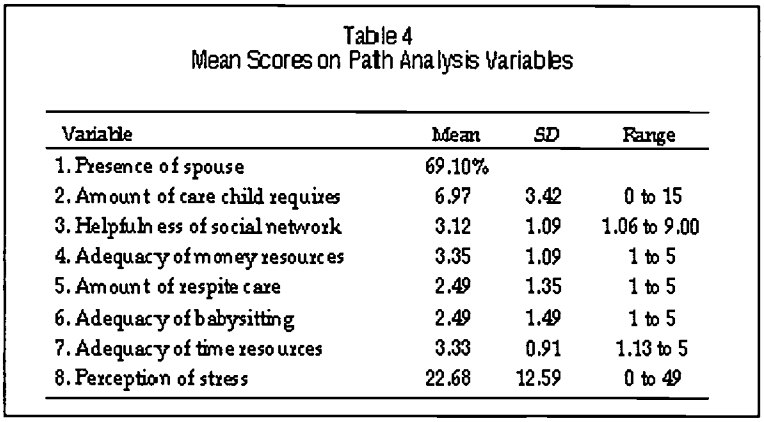


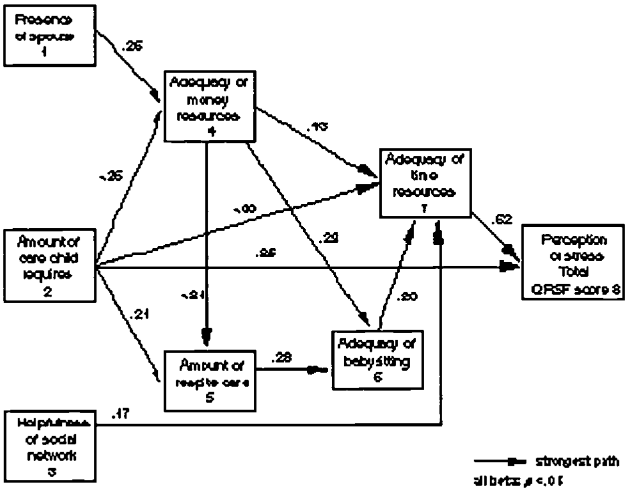
Table 4
Mean Scores on Path Analysis Variables

Variable	Mean	*SD*	Range
1. Presence of spouse	69.10%		
2. Amount of care child requires	6.97	3.42	0 to 15
3. Helpfulness of social network	3.12	1.09	1.06 to 9.00
4. Adequacy of money resources	3.35	1.09	1 to 5
5. Amount of respite care	2.49	1.35	1 to 5
6. Adequacy of babysitting	2.49	1.49	1 to 5
7. Adequacy of time resources	3.33	0.91	1.13 to 5
8. Perception of stress	22.68	12.59	0 to 49

[Home] [Search] [Index]

Figure 2
Return to Article

Figure 2
Path Analysis Flow Chart



BEST COPY AVAILABLE

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida, 1996

Parent-Professional Collaboration: A Pilot Study of Parents as Researchers

Authors

Introduction Method Results Discussion References
Return to Table of Contents

Current Trends in Children's Mental Health

Central to the efforts to enhance the delivery of broad based services to families of children with severe emotional and behavioral problems is the recognition that a new philosophy and set of practice values must be a fundamental part of systems change (Behar, 1988; Burchard, et al, 1991; Homonoff & Maltz, 1991). This new philosophy (e.g., Lourie, et al, 1990; Raiff, 1990; Ronnau, 1991; Stroul & Friedman, 1986; Ventura County Children's Mental Health Services Demonstration Project, 1987) focuses on such values as emphasizing family and child strengths, respecting the needs, wants and desires of families and children, and maintaining children in the most family-like environment.

Significant progress has been made in developing child and family services grounded in a family strengths based philosophy (e.g., Stroul, 1993), however, to date, programs are only just beginning to incorporate the family strengths, family based perspective into program evaluation research design and methodology. If we are to maintain our commitment to empowering families from a strengths based perspective, and to expand the opportunities for enhanced parent-professional collaboration, we must develop innovative methodologies which consider families as full participants in all aspects of ongoing program evaluation research.

This summary describes one project, undertaken in the State of Maine, to involve parents as researchers in collaborative action research. Collaborative action research suggests that each group represented in the process "shared in the planning, implementation, and analysis of the research and that each contributes different expertise and a unique perspective" (Oja & Smulynam, 1989; p. 1). Collaborative action research represents an attempt to empower people proactively, and to study research problems which arise out of a community, rather than solely through the eyes of the researcher. In collaborative action research, parents and researchers work together to set common goals and mutually plan the research design, collect and analyze data, and report results. Collaboration assumes that researchers and parents will communicate frequently and openly throughout the process to avoid possible conflicting perceptions and assumptions which result from their different perspectives.

Return to Top

The Intensive Child Case Management Program

This pilot study grew out of an ongoing program evaluation of a new intensive child case management program in the state of Maine. The intensive child case management services are part of a continuum of child and adolescent mental health services developed and implemented by the state of Maine Department of Mental Health and Mental Retardation. This continuum of services (e.g. child case management, crisis services, community-based residential services, etc.) was legally mandated following agreement of a class action suit between mental health consumer groups and state mental health and human services officials, resulting in a substantial decrease in the number of state hospital beds for adults, a virtual elimination of state hospital beds for children and adolescents, and increased funding allocations for improving and expanding community based mental health services. Six agencies were awarded four year contracts with the state department of mental health to provide intensive child case management services.

We were interested in understanding parents' perceptions regarding their involvement and satisfaction with intensive child case management services; therefore, we proposed a collaborative research model in which parents were active participants in all aspects of the evaluation of parent satisfaction.

We want to emphasize several important points about this pilot project:

- This is a small pilot study&shyp;we were only funded for $5,000. Money is nice, but you don't have to have a lot of it!
- We are trying to accomplish the project in an incremental fashion by using this model in one region of the state, and then replicating our efforts in other regions.
- Above all, we wanted to develop and refine family strengths based research methodology that was "family friendly" and could be used by the families themselves.

Return to Top

The Pilot Study

First, we conducted two focus groups with parents of children with serious emotional and behavioral disabilities (who received case management services) in order to obtain parents' recommendations regarding the conduct of family strengths based research, and to recruit for parent researchers.

What did we find?

1. Parents want evaluation research that doesn't exclusively focus on family dysfunction and problems.
2. Parents feel blamed and judged by professionals already&shyp;they don't want to be evaluated from a problem focus.
3. Parents want researchers to spend more time with them&shyp;i.e., "Come to our houses and spend some time with us in order to more accurately observe our family and child situation."
4. Parents believe that there is no accountability in the system for child outcomes, and they want evaluation of service providers to stress accountability and responsiveness to families and children. They want an accountable system, which includes ongoing assessment, quality assurance and evaluation.
5. Parents want more collaboration among providers and parents&shyp;and this includes researchers. Parents want to participate in the evaluation process through periodic updates, ongoing participation in focus groups and participation in data collection.

Recruitment of Parents as Participants on the Research Team

We recruited parent-researchers from participants in the focus groups. Due to budget constraints on the project, only one parent was able to get paid and work on the project. The parent-researcher kept a notebook of her experiences, feelings and thoughts as she participated in this project.

Creation of Semi-Structured Interview

Based on thematic analysis of the focus groups' discourse, we developed a semi-structured interview aimed at discovering parental satisfaction with intensive child case management services. The interview consisted of open-ended questions related to characteristics of the child and family, parental satisfaction with the system of care, service needs and barriers, and history of service use. We spent time assessing the interview format in order to insure that the interview was strengths based and family and child focused.

We taped the interviews and transcribed the notes, working in teams for the purpose of conducting interviews. The evaluator did the initial interview with the parent-researcher observing. Next, the parent-researcher completed two interviews as the lead interviewer, with the evaluator as the observer. After each interview, we processed how the interview was conducted, what could be changed and what was working well. Four interviews have been completed to date.

What have we learned so far?

1. Families find great satisfaction with a case manager who does not take over, causing the family to be totally dependent on them, but rather offers suggestions and service options to help the family find out what it is that works best for them.
2. Families are pleased when they do not receive criticism, but instead are given unconditional acceptance from their case manager, being applauded for what the family feels are their successes.
3. Families appreciate and benefit from a case manager who encourages a family to ask questions and does not appear to perceive them as a nuisance when they do so. Case managers should give families adequate information to insure the best possible communication between them.
4. Families also appreciate case managers who perceive the family as being comprised of individuals who are part of the same whole. Much consideration of other family members' needs must be taken into account, strengthening the entire family, if the child is to succeed within her or his own home.
5. Families want and expect a case manager to advocate with them on a consistent basis with the schools, their communities, and local and state government, and not remain in the background simply hoping that change will magically come about. They want their case managers to be knowledgeable about services and to make a strong stand that will directly effect the creation and availability of child and adolescent mental health services.

Return to Top

Comments from the Parent-Researcher

Parents as researchers can serve as role models of empowerment for families who are being interviewed. It is empowering for families to perceive others parents of children with SED as being a valued part of the research process which can directly effect change in the way mental health services will be delivered in the future. Parents of children with SED are often perceived as dysfunctional by professionals in the system and may be reluctant to confide&shyp;fearing blame for their children's illness. Such is not the case when families converse with one another.

Families who have experienced similar difficulties with the system have little if any difficulty confiding their problems to each other. Parents have remarked during the interview that I "must know how they feel," and they visibly relax. I feel that a climate of trust directly effects the amount of detailed information that can be elicited. Families experience validation when asked to share their "stories" with another parent. Parent researchers assume a unique and important role for families, serving to authenticate families' experiences through the interview process.

As a parent researcher who has had the opportunity to interview other parents about their child's case management service, I have some recommendations for the training of parent researchers:

- Give parent researchers the opportunity to explore their own value conflicts and prejudices before they conduct their first interview . I experienced the awful reality of such prejudice during my first encounter with a parent subject in her home. Her home did not meet my standards of cleanliness, and for a brief moment I wondered if the reason why her children were so ill was because of living in such an environment. Fortunately, a light of recognition went off in my head, and I was forced to take a long hard look at my own value conflicts.

- Parent researchers need training to understand the different styles of communication they may encounter in interviews. I am a talkative person, and found I needed to slow down for a more quiet parent.

- Parent researchers need the opportunity to practice interview skills. Prospective parent researchers should practice interviews with one another. They should focus on tact, diplomacy and speaking clearly so families can easily comprehend. Their goals should include developing good listening skills to extract the meat from the dialogue, learning to probe for information&shyp;while not being overly invasive and interrogatory&shyp;and being careful not to overwhelm the subjects being interviewed.

- Parent researchers need practice learning to focus on the parent subjects, and allowing the home environment to provide added information without distracting researchers from the purpose of their visit. My first home interview involved kids, phones, dogs and other interruptions. I needed to "go with the flow."

- Give parent researchers many opportunities to discuss their own feelings of distress when listening to a subject who is expressing similar painful issues that may mirror the interviewers own experiences. Provide parent researchers with a mechanism to deal with those feelings, both for themselves and for the integrity of the interview, so that there is no subtle hint of leading the subject into an area which may serve to validate the interviewer, but which could contaminate that interview with bias.
  Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies,
Florida Mental Health Institute, University of South Florida,1996

The Significance of V61.xx - Family Problems in Mental Health Care for Children

Authors

Introduction Method Results Discussion References
Return to Table of Contents

Introduction

With completion of field trials for the American Psychiatric Association Diagnostic and Statistical Manual, 4th edition (DSM-IV; APA, 1994), we have further refined psychiatric nomenclature. One problem, however, is that children and families having difficulties do not always fit into present diagnostic schemes. This noncon-formity may be to the detriment of mental health clinicians and the children and families they treat. It also may lead to an inability to access services.

For example, a recent ruling in one state requires a child to have a major psychiatric diagnosis in order for child guidance clinic resources to be allocated; the non-specific DSM-IV diagnosis of Family Problems-V61.xx is not sufficient criteria for the allocation of services. Clinical experience suggests, however, that Family Problems may be the salient presentation for a child and family who are considerably distressed and can make significant use of clinical assistance. For many of these families, the focus of the clinical effort is toward locating the source of distress.

The hypothesis tested in this study was that children who present with Family Problems (V61.xx) are as distressed and make use of clinical assistance as much as those with major DSM-IV psychiatric diagnoses.

Return to Top

Method

Setting

This study used data from a chart review of a child guidance center located in a community mental health center. The child guidance center was the sole child mental health practice in the community, had a sliding fee, and was state funded and completely independent of third party payers. The community in which the child guidance center was located was a suburban working class community of 54,000, with a median household income of $35,000-40,000. Six percent of the households were below poverty level in income, while 2.6% of the households had incomes above $100,000. The racial/ethnic mix of the community was 82% Caucasian, 12% African American and 5% of other ethnic origins.

Measurements

This study used a retrospective record review of all children seen in a single community mental health center. Information abstracted from the records included:

- Demographic information
- All diagnoses
- Dates of all visits

- Child global assessment scores, when available

The diagnosis of Family Problems and five psychiatric diagnoses (Adjustment Disorder, Dysthymia, Oppositional Defiant Disorder, Conduct Disorder and Major Depression) were examined in detail with regard to:

- Number of additional diagnoses
- Follow-up time
- Number of visits
- Child global assessment scale scores on presentation

Return to Top

Results

Six hundred thirty eight children were seen more than once between July 1980 and December 1993 in this community child guidance clinic. The racial mix of children seen in the clinic matched the racial mix of the community. The average age of the children was 10 years old, and these children were seen for an average 16 visits (SD=19). The average child global assessment scores for 376 of these children was 61 ± 10 (range 20 to 85).

Family Problems was found to be a presenting problem in 55% of the children who presented, and in 26% of these children, it was the sole diagnosis. Family Problems (9.6 yrs), adjustment disorder (9.8 yrs) and oppositional defiant disorder (9.4 yrs) tended to present at a younger age than dysthymia (12.0 yrs), major depression (13.3 yrs) and conduct disorder (12.3 yrs). The average child global assessment score for children with a diagnosis of Family Problems was 63, and only children with conduct disorder and major depression had CGAS scores that were statistically significantly lower than children with family problems.

Children presenting with Family Problems were followed for as long and for as many visits as most other psychiatric diagnoses. On subsequent presentations, these children many times presented with more prominent psychopathology. For example, of the 209 children who presented to the clinic for a second set of visits, 51 presented with dysthymia, 45 presented with oppositional defiant disorder, 18 with drug and alcohol problems, 15 with attention deficit disorder, 15 with conduct disorder, and 15 with major depression. Five children subsequently presented with either psychosis or bipolar disorder.

Return to Top

Conclusion

Family Problems is a common diagnosis in a child guidance clinic population. Although the inclusion of nonspecific diagnoses such as "V" codes may seem as an invitation for children and families with less severe disturbances to use services, this study demonstrates that these children may be just as impaired as other children with major psychiatric diagnoses. A diagnosis of Family Problems is not predictive of less need. Results are also consistent with the hypothesis that Family Problems may be the initial presentation of chronic disability in some cases. These tentative conclusions are provocative with respect to preventive mental health care and the line between acute psychiatric manifestations and chronic social disability. In addition, children presenting with Family Problems tend to be younger, which has secondary preventative implications.

The clinic used in this study was not constrained by pressures that normally require the use of Axis I diagnoses in order to allocate resources. It is for this reason that the "V" codes of Family Problems could be used as a sole diagnosis. When clinicians are required to use Axis I diag-noses, as they are in most clinical settings, conflicts arise. Any diagnostic nomenclature will have inherent limitations, including the difficulties of categorization which lead to the social stigma of labeling. In addition, our present nomenclature does poorly in characterizing younger children. Clinicians may be forced to use diagnoses that are not appropriate due to these limitations.

Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

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Florida Mental Health Institute, University of South Florida, 1996

The Influence of Family Functioning on the Incidence of Conduct Disorder Among Children and Adolescents

Authors

Introduction Method Results References
Return to Table of Contents

Introduction

The prevalence of conduct disorder among children and adolescents is quite disturbing given that conduct disorder is often identified as a precursor of more severe emotional and behavioral problems (Graham & Rutter, 1973). Empirical research examining causes of conduct disorder typically focus either on family functioning (Greenberg, Speltz, & DeKlyen, 1994; Patterson, Reid, & Dishion, 1992) or peer relationships and school context (Coie & Jacobs, 1993; Coie, Dodge, & Kupersmidt, 1990). From a developmental perspective, examining associations between conduct disorder and family relationships is critical because these are children's first relationships (Ainsworth, 1989). Theoretically, family relationships are expected to be resistant to change because these relationships and interaction patterns have been in place longer than other social relationships (Martin, 1987).

Given the potential impact of family on conduct disorder, this investigation sought to examine associations among family functioning and conduct disorder among children and adolescents currently receiving mental health services. Specifically, the present investigation was designed to answer three questions. First, how stable are family functioning characteristics and children's conduct disorder over a six-month interval? Second, what is the nature of the relationship between family functioning and children's conduct disorder? Finally, is the association between family functioning and conduct disorder dynamic with changes in family functioning being associated with changes in children's behavior?

Return to Top

Methods

Subjects

All data included in this investigation were collected as part of the Fort Bragg Evaluation Project (FBEP; Bickman, Heflinger, Pion, & Behar, 1992) and included 5 to 17 year old children and their parents. Of the 819 participating children, 519 were male. The majority of children participating were Caucasian (72%), and resided with two parents (either biological or step-parents: 87%). Twenty-six percent were clinically diagnosed as having a conduct disorder (see Table 1).

Measures

Data collected from the first two assessments of the FBEP were included. Time 1 data were collected upon entry into mental health services and time 2 data were collected six months later. While not all families were seeking services for conduct disorder, all families were soliciting services for children's mental health problems. Parents participated in structured interviews and completed a variety of measures at times 1 and 2, some of which included assessments of family functioning and children's conduct disorder.

Family Functioning

Parents completed the Family Inventory of Life Events (McCubbin, Patterson, & Wilson, 1981). Seventy-one items were dichotomously rated as yes or no by parents. If the event had occurred within the past six months, parents responded yes. The family conflict, marital strains, and pile up of stress subscales were used in these analyses. Parents also completed the Family Assessment Device (Epstein, Baldwin, & Bishop, 1983). Parents rated 60 items on a 4 point Likert scale (strongly agree to strongly disagree) in terms of how much it described their family during the previous six months. The problem-solving/communication, affective responsiveness, affective involvement, general functioning, and behavioral control subscales were included.

Conduct Disorder
To assess children's level of conduct disorder, parents completed the Child Assessment Schedule (CAS; Hodges, Kline, Stern, Cytryn, & McKnew, 1982) and the Child Behavior Checklist (Achenbach, 1991). The acting out subscale from the CAS and the delinquency and aggression subscales from the CBC were used to index conduct disorder. These three scores were significantly correlated and were standardized and summed to create the conduct disorder composite.

Return to Top

Result and Implications

The goals of this investigation were to determine the relative stability of family functioning and children's conduct disorder over time, the relationship between levels of family functioning and concurrent and subsequent child behavior, and the associations among family functioning and changes in children's behavior. Before addressing these questions, the family functioning and conduct disorder variables were compared by age and gender. While few gender differences emerged, age was significantly associated with all variables, except marital strains, such that having an older child was indicative of greater functioning and behavioral problems across both time intervals.

To determine the relative stability of family functioning and conduct disorder over time.

Stability was assessed by correlating time 1 and time 2 scores (see Table 2). Family functioning showever, these correlations were low enough to indicate that, while time 1 functioning may be a good predictor of time 2 functioning, time 1 scores were not a perfect predictor of time 2 functioning. Children's conduct disorder scores were somewhat more stable across the 6 month interval, but change in conduct disorder was also apparent.

To determine the relationship between level of family functioning and concurrent and subsequent conduct disorder.

Three hierarchical regression equations were computed to examine the relationships between family functioning and children's behavior. In each regression equation children's age and gender were entered first and accounted for 1-2% of the variance associated with conduct disorder. Of particular interest was the amount of change in R2 upon entry of the family functioning variables (see Figure 1). Time 1 family functioning resulted in a significant change in R2 when predicting time 1 conduct disorder and accounted for 22% of the variance. Similarly, time 2 family functioning variables resulted in a significant change in R2 and explained 28% of the variance associated with time 2 conduct disorder. Time 1 family functioning variables resulted in a significant change in R2 when predicting time 2 conduct disorder and explained 12% of the variance.

In sum, family functioning was significantly associated with concurrent levels of conduct disorder across both time intervals. Thus, families who are functioning poorly are likely to have children who are experiencing behavioral problems. A relationship between levels of family functioning at time 1 and conduct disorder at time 2 was also found, however, this lagged relationship was not as strong as concurrent associations between family functioning and conduct disorder. Since level of family functioning at time 1 was not as strongly associated with children's time 2 behavior as family functioning at time 2, change in functioning may be occurring.

To determine whether family functioning was related to changes in children's behavior from time 1 to time 2 .

In determining the relationship between family functioning and changes in children's behavior, residual change scores were used to parallel the multiple regression methodology of the previous analyses. In the first step of each equation, children's time 1 conduct disorder scores were entered and accounted for 49% of the variance of time 2 conduct disorder. Thus, the remaining variance is variance which is independent from conduct disorder at time 1, or changes in conduct disorder from time 1 to time 2. In each of these three equations, age and gender were entered in the second step and resulted in no change in R2. Finally, the family functioning variables were entered. As with the previous regression equations, the focus was on the amount of change in R2 associated with entry of the family functioning variables in predicting change in conduct disorder (see Figure 2). Thus, separate regression equations were computed with family functioning at time 1, at time 2, and changes from time 1 to time 2 entered in the third step.

When predicting changes in children's behavior from time 1 family functioning, no significant change in R2 emerged. Time 2 family functioning resulted in a significant change in R2 of .10 when predicting changes in children's conduct disorder from time 1 to time 2. To examine the association between changes in family functioning and changes in children's conduct disorder, time 1 family functioning scores were entered. Since time 1 family functioning scores correlated significantly with time 2 functioning scores, these commonalities were partialled out. Entry of the time 2 family functioning variables resulted in a significant change in R2 of .11, indicating that changes in family functioning from time 1 to 2 were associated with changes in children's behavior from time 1 to time 2.

These regressions were designed to examine the relationship between family functioning and change in children's conduct disorder. The results indicate that level of family functioning at time 1 was not a good indicator of change in children's behavior, rather children's behavior changed independently of families previous functioning. Time 2 family functioning and changes in family functioning were good indicators of change in children's behavior. Thus, children who are receiving treatment, and the families in which they reside, seem to be changing together.

In conclusion, all children in this sample were receiving mental health services, although not necessarily for conduct disorder. Across both time periods, family functioning, and to a lesser extent, children's behavior, were not stable. Determining causation is difficult. One possible explanation of these results is that changes in children's behavior led to changes in family functioning. Alternatively, changes in family functioning, for instance, reduction in stress or improved communication skills, may result in improvements in children's behavior. From a family systems perspective, both of these hypotheses are valid. Systemically, change in one domain should influence change in another. Thus, a model of reciprocal causality may be needed, such that changes in children's behavior lead to changes in family functioning which causes further changes in behavior. Further research examining this more dynamic view of families and children is clearly needed.

Return to Top

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Return to Top

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Return to Top

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[Home] [Search] [Index]

Table 1

Return to Article

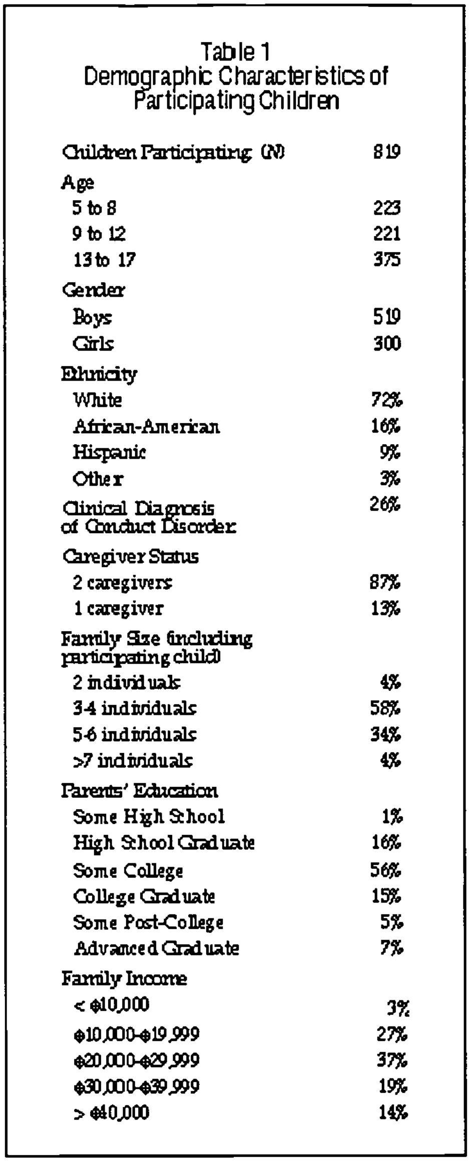


Table 1
Demographic Characteristics of Participating Children

Children Participating (N)	819
Age	
5 to 8	223
9 to 12	221
13 to 17	375
Gender	
Boys	519
Girls	300
Ethnicity	
White	72%
African-American	16%
Hispanic	9%
Other	3%
Clinical Diagnosis of Conduct Disorder	26%
Caregiver Status	
2 caregivers	87%
1 caregiver	13%
Family Size (including participating child)	
2 individuals	4%
3-4 individuals	58%
5-6 individuals	34%
>7 individuals	4%
Parents' Education	
Some High School	1%
High School Graduate	16%
Some College	56%
College Graduate	15%
Some Post-College	5%
Advanced Graduate	7%
Family Income	
< $10,000	3%
$10,000-$19,999	27%
$20,000-$29,999	37%
$30,000-$39,999	19%
> $40,000	14%

[Home] [Search] [Index]

Table 2

Return to Article

Table 2
Correlations Between Time 1 and Time 2 Family Functioning and Children's Conduct Disorder

	r value
Family Functioning	
1. Family Conflict	.42*
2. Marital Strains	.40*
3. Pile-up of Stress	.54*
4. Problem-Solving & Communication Skill	.59*
5. Affective Responsiveness	.59*
6. Affective Involvement	.55*
7. Behavioral Control	.57*
8. General Functioning	.60*
Conduct Disorder	.70*

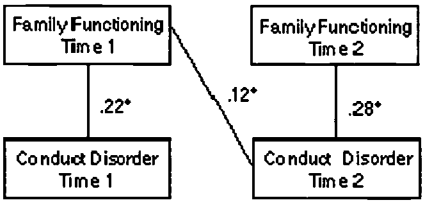
* $p < .000$

[Home] [Search] [Index]

Figure 1

Return to Article

Figure 1
Hierarchical Regression Equations
Predicting Children's Conduct Disorder:
Change in R^2 Values after Controlling
for Age and Gender

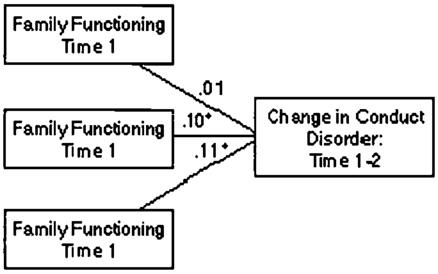


$^*p<.001$

[Home] [Search] [Index]

Figure 2
Return to Article

Figure 2
Hierarchical Regression Equations
Examining Association
Between Family Functioning and
Changes in Conduct Disorder:
Descriptions of the Changes in R^2



*$p<.001$

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Facilitating the Social/Emotional Development of Middle School Students: A Model for Improving School-Based Collaboration

Authors

Introduction Method Results Discussion References

Return to Table of Contents

Introduction

Project Destiny (Designing Educational Support Teams through Interagency Networks for Youth with Emotional or Behavioral Disorders) is a three year training and research project funded by the US Office of Education and Rehabilitative Services. It is part of an initiative to improve school-based services for students with emotional or behavioral disorders (EBD), which was established under the Individuals with Disabilities Education Act of 1990 (IDEA). The project assesses the impact of staff development and school-wide intervention programs on the performance of students with EBD who are included in general education classrooms. We have discussed the entire project elsewhere (Cheney & Barringer, 1995 : Cheney, Barringer, Upham & Manning, 1995). The present discussion focuses on baseline assessments of (a) existing service models, (b) teacher competencies, and (c) student characteristics.

Return to top

Method

Subjects/Sites. Subjects were 113 middle school students (grades 5-8); and 25 teachers, with an average of 18 years experience. Subjects were selected from two New Hampshire communities, one suburban (pop. < 75,000) and one rural (pop. = 10,000). Using a multiple gating procedure (Walker, Severenson, Stiller, Williams, Haring, Shinn & Todis, 1988; Walker & Severnson, 1992), teachers identified 67 students with EBD, 6 of whom had been classified as Seriously Emotionally Disturbed (SED) under special education law; teachers also identified 46 students whom they considered typical for age and grade level.

Intervention Program. During three consecutive school years, a research team comprised of a special educator, a psychologist and a family counselor will provide: (a) monthly didactic presentations to staff, (b) bi-monthly case studies , (c) parent support groups, and (d) consultation concerning school-wide interventions (e.g., problem solving approaches, social skills curricula, and crisis prevention techniques).

The framework for these interventions is the Project Destiny Transdisciplinary Model (see Table 1), which is based on research in the fields of child and adolescent development (Bowlby, 1988, Kholberg, 1984), developmental psychopathology (Cicchetti, 1993; Cicchetti & Toth, 1992), and special education (Walker, Colvin & Ramsey, 1994). This model program provides guidelines for creating a school context that facilitates the social-emotional development of all students, and provides extra support for students with EBD. A fundamental assumption of the model is that social/emotional development, a primary determinant of school performance, is influenced by four developmental factors, (1) biological factors, (2) affective factors, (3) interpersonal/familial factors and (4) cognitive factors

Measurement Instruments. The research design for the project calls for 15 instruments to be administered at the beginning and end of each school year. This report, however, concerns only the following subset of instruments:

1. Assessment of School Context Survey (see Table 1),
2. Teacher Competency Survey (Bratten, 1993),
3. Social Skills Rating Scale (Gresham & Elliot, 1990),
4. Teacher Report Form (Achenbach, 1991),
5. Inventory of Parent & Peer Attachment (Armsden & Greenberg, 1987),
6. Youth Self Report (Achenbach, 1991), and
7. Reynolds Adolescent Depression Scale (Reynolds, 1986).

Using these instruments, informants indicated their agreement/disagreement with the specific aspects of the proposed model program; and compared existing service delivery systems to the model. Informants also rated the competence of teachers, as well as the behavior, academic performance, social skills and emotional functioning of students. Other data (e.g., achievement test scores and teacher's comments) were collected using archives, direct observations, and interviews.

Return to top

Results

Service Delivery Systems. Teachers who completed the Assessment of School Context Survey agreed with 23 of the 26 components of the proposed model. Teachers further indicated that the service delivery systems in their schools lacked most of the components specified in the model (e.g., family support groups, an adequate number of consulting specialists, and adequate planning time for teachers and students). All schools used IDEA (1990) as their service delivery model, under which less than 12% of students with EBD received services; often these were not the students of greatest concern to teachers.

Teacher Competence. As reported elsewhere (Cheney & Barringer, 1995), classroom teachers rated themselves as having little or no knowledge concerning (a) the course of normal social/emotional development, (b) federal and state definitions and regulations pertaining to EBD, (c) the functions of community agencies providing services to this population, (d) characteristics of students and their families, (e) individual differences among students with EBD, and (f) relevant constructs from the fields of mental health and education. As expected, teachers reported greater expertise with respect to managing group behavior in the classroom and using appropriate instructional techniques. In general, teachers did not feel competent, and reported high levels of frustration, with respect to integrating students with EBD into their general education classrooms.

Student Characteristics. Using a multiple-gating procedure, teachers accurately differ- entiated youth with EBD from typical students; in the sample of 113 students, there were 7 false positives and 0 false negatives. Students with EBD differed from the typical group on virtually all measures.

Teachers' reports were also valid indicators of students scores along the internalizing/externalizing dimension (Achenbach & Edelbrock, 1983). Finally, students who had been classified SED under special education law differed significantly from unclassified students with EBD on only three variables: the classified group's behavior was rated as more internalizing, and they showed a greater degree of idiosyncratic thinking; the unclass-ified students with EBD showed greater elevations on the externalizing and aggression subscales.

A subsequent K-Means Cluster Analysis (see Table 2) yielded three groups of students: The Typical group (n = 46) showed well developed social skills and no serious emotional, behavioral or academic problems; these students' self-ratings in all of these areas were generally consistent with those obtained from teachers and parents.

In contrast, the Aggressive/Academic Problem group (n = 34) scored below average with respect to social skills and in all academic subjects. Their TRF scores also showed significant problems with aggressive behavior, delinquency, inattention and idiosyncratic thinking. These social-emotional difficulties were reported by teachers, but not by the students, who ranked themselves within the average range on all YSR subscales.

Students in the Aggressive/Depressed group (n = 33) were similar to those in the Aggressive/Academic Problem group: their TRF scores indicated significant problems in the areas of aggressive behavior, delinquency, idiosyncratic thinking and social skill development; unlike the Aggressive/Academic Problems group, however, their academic achievement was within normal limits despite indications that they were socially withdrawn and well above the clinical cut-off on the depression measure. In addition, compared to their teachers' ratings, students in the Aggressive/Depressed group rated themselves as having more, and more severe emotional problems.

There were also significant differences between groups with respect to their attachments to their mothers and fathers: as expected, the Typical group demonstrated the strongest attachment to parents and showed equivalent attachment to their mothers and fathers; average attachment scores were lower for both the Aggressive/Academic Problems group and the Aggressive/Depressed groups. These two groups showed similar scores, and both groups appeared to have a stronger attachment to mother than to father.

Return to top

Discussion

At baseline, all schools relied exclusively on the administrative guidelines in IDEA (1990) as a model for service allocation. The majority of students with EBD have not been well-served by this model (Carson, Sitlington & Frank, 1995; Chesapeake Institute, 1994; Cheney & Harvey, 1994; Wagner, Newman, D'Amico, Jay, Butler-Nalin, Marder & Cox, 1991); our results are consistent with previous findings concerning this issue.

Our baseline data indicated that a small percentage (< 12%) of students with EBD were involved with special education programs; in addition, classroom teachers were not prepared to deliver educational services to students with EBD. Teachers were aware of students who needed additional support; however, they hesitated to make referrals for special education services due to social stigma, parental reaction, or problems obtaining timely evaluations and follow-up services.

Constructing responsive school contexts requires an understanding of differences in students' social-emotional development. In the Project Destiny middle schools, students with EBD showed important differences with respect to, (a) signs of clinical depression, (b) attachment to father, (c) social withdrawal, (d) academic achievement, and (e) self-awareness concerning the types of emotional and behavioral problems of concern to their parents and teachers. Such fundamental, developmental differences may account for some of the variance in the effectiveness of behavioral techniques commonly used with this population (e.g., contracting, contingency management, social skills training); we will collect additional data during the next two years of the project, and attempt to further study this issue.

Collaborating with students to facilitate social/emotional development involves structuring their interactions with people and materials in the environment according to mutually agreed upon goals.

In the ideal case, the differential impact of developmental variables on the performance of students will determine the kinds of school-based services each student receives; students' needs also will determine both the nature of staff development and the types of interactions that will facilitate social/emotional development. Determining the concordance of data concerning students' needs collected from families, teachers, community specialists and, most importantly, the students themselves, can provide a basis for collaboration; for example, compared to students in the Aggressive/Academic Problems group, students in our Aggressive/Depressed group seemed to be more aware of the problems identified by their teachers, and therefore may be relatively more amenable to collaborating on solutions.

Focusing on how an individual interacts with people and materials in the environment is a common practice in clinical settings; however, this notion may be new, and seem impractical to middle-school teachers and administrators, who have been mainly concerned with large groups of students, rather than individuals within the group. Meaningful inclusion of young teens with EBD in general education requires that teachers, administrators, parents and students share an understanding of how to best facilitate the individual student's social emotional development. Presently, the absence of a shared developmental model is an obstacle to this sort of collaboration , and thus blocks the full inclusion of students with EBD in the educational process. Over the next two years, Project Destiny will assess the utility of an empirically based developmental model for inclusion of students with EBD in general education.

Return to top

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Return to top

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Return to top

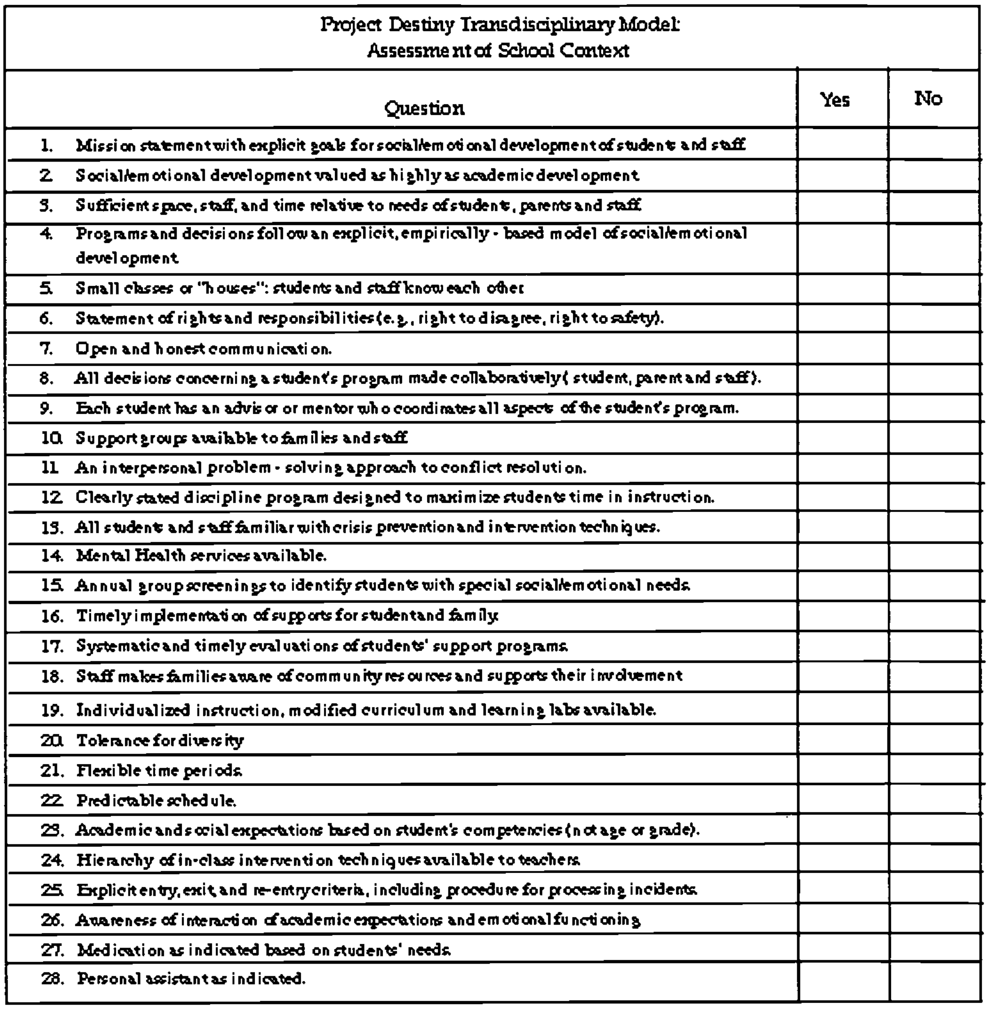
[Home] [Search] [Index]

Table 1

Return to Article

Table 1

Project Destiny Transdisciplinary Model



Project Destiny Transdisciplinary Model:
Assessment of School Context

Question	Yes	No
1. Mission statement with explicit goals for social/emotional development of students and staff		
2. Social/emotional development valued as highly as academic development		
3. Sufficient space, staff, and time relative to needs of students, parents and staff		
4. Programs and decisions follow an explicit, empirically - based model of social/emotional development		
5. Small classes or "houses": students and staff know each other		
6. Statement of rights and responsibilities (e.g., right to disagree, right to safety).		
7. Open and honest communication.		
8. All decisions concerning a student's program made collaboratively (student, parent and staff).		
9. Each student has an advisor or mentor who coordinates all aspects of the student's program.		
10. Support groups available to families and staff		
11. An interpersonal problem - solving approach to conflict resolution.		
12. Clearly stated discipline program designed to maximize students time in instruction.		
13. All students and staff familiar with crisis prevention and intervention techniques.		
14. Mental Health services available.		
15. Annual group screenings to identify students with special social/emotional needs.		
16. Timely implementation of supports for student and family.		
17. Systematic and timely evaluations of students' support programs.		
18. Staff makes families aware of community resources and supports their involvement		
19. Individualized instruction, modified curriculum and learning labs available.		
20. Tolerance for diversity		
21. Flexible time periods.		
22. Predictable schedule.		
23. Academic and social expectations based on student's competencies (not age or grade).		
24. Hierarchy of in-class intervention techniques available to teachers.		
25. Explicit entry, exit, and re-entry criteria, including procedure for processing incidents.		
26. Awareness of interaction of academic expectations and emotional functioning		
27. Medication as indicated based on students' needs.		
28. Personal assistant as indicated.		

[Home] [Search] [Index]

Table 2
Return to Article

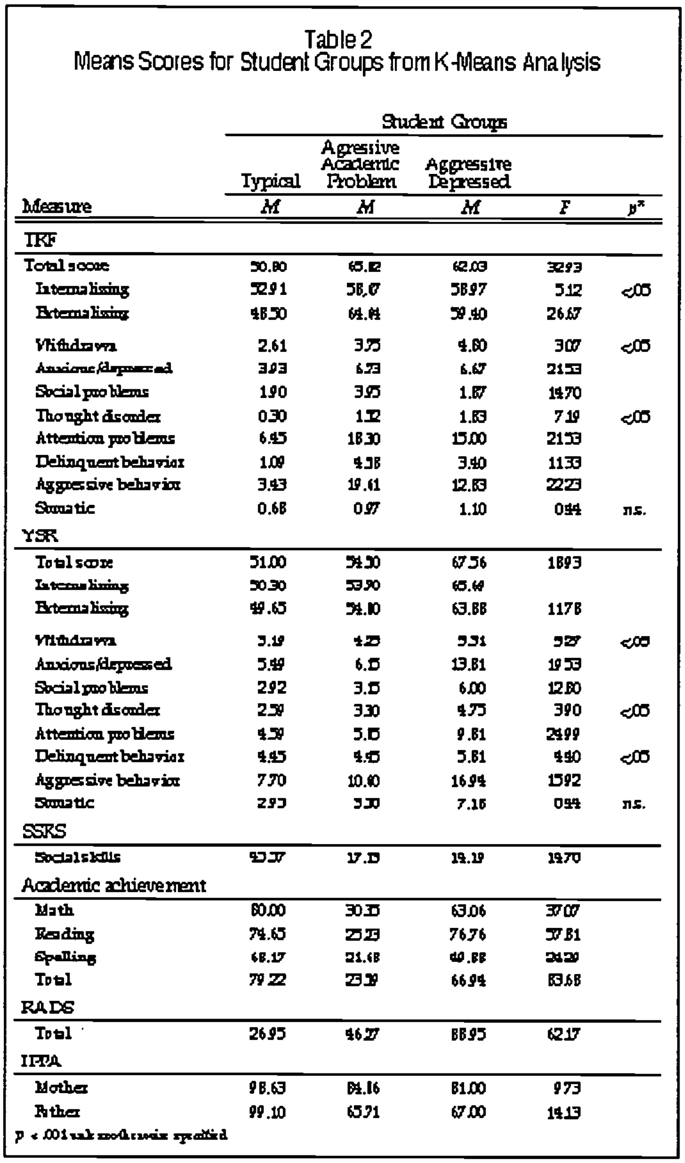


Table 2
Means Scores for Student Groups from K-Means Analysis

	Student Groups				
	Typical	Agressive Academic Problem	Aggressive Depressed		
Measure	*M*	*M*	*M*	*F*	*p**
IRF					
Total score	50.80	65.82	62.03	32.93	
Internalising	52.91	58.07	58.97	5.12	<.05
Externalising	48.50	64.44	59.40	26.67	
Withdrawn	2.61	3.75	4.80	3.07	<.05
Anxious/depressed	3.03	6.73	6.67	21.53	
Social problems	1.90	3.95	1.87	14.70	
Thought disorder	0.30	1.32	1.83	7.19	<.05
Attention problems	6.45	18.30	15.00	21.53	
Delinquent behavior	1.09	4.38	3.40	11.33	
Aggressive behavior	3.43	19.61	12.83	22.23	
Somatic	0.68	0.97	1.10	0.44	n.s.
YSR					
Total score	51.00	54.30	67.56	18.93	
Internalising	50.30	53.90	65.60		
Externalising	49.65	54.10	63.88	11.78	
Withdrawn	3.19	4.25	5.31	5.27	<.05
Anxious/depressed	5.49	6.15	13.81	19.53	
Social problems	2.92	3.15	6.00	12.80	
Thought disorder	2.59	3.30	4.75	3.90	<.05
Attention problems	4.59	5.15	9.81	24.99	
Delinquent behavior	4.45	4.95	5.81	4.40	<.05
Aggressive behavior	7.70	10.40	16.94	15.92	
Somatic	2.93	3.30	7.16	0.44	n.s.
SSRS					
Social skills	93.37	17.15	14.19	19.70	
Academic achievement					
Math	80.00	30.35	63.06	37.07	
Reading	74.65	25.23	76.76	57.81	
Spelling	68.17	21.68	60.88	24.29	
Total	79.22	23.39	66.94	83.68	
RADS					
Total	26.95	46.27	88.95	62.17	
IPPA					
Mother	98.63	84.16	81.00	9.73	
Father	99.10	65.71	67.00	14.13	

p < .001 unless otherwise specified

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies,
Florida Mental Health Institute, University of South Florida, 1996

School-Based Wraparound: How Implementation and Evaluation Can Lead To System Change

Authors

Introduction Method Results Discussion References
Return to Table of Contents

Introduction

Specific special education initiatives in Illinois have been developed to implement wraparound models similar to those found in mental health and child welfare as a way to improve outcomes for children with emotional and behavioral disabilities (EBD) and their families. These programs provide and coordinate services that address all life domains, are strength-based and family-centered. Base-line data were collected on 81 students which included descriptive characteristics, student and family outcomes. Improvements were seen in family functioning, emotional and behavioral functioning of the students, and reduction in the use of psychiatric hospital days.

During the 1993-94 school year, the Illinois State Board of Education (ISBE) funded the Emotional and Behavioral Disability Partnership Initiatives. These projects have been involved in developing individualized services and supports for students with EBD in natural home, school and community settings. Given that these students have complex needs and often require multiple services, a critical component of these projects was to develop interagency networks that facilitate coordinated and comprehensive plans for students and families. These initiatives cultivated partnerships among community agencies and encouraged new ways to use existing resources and improve service delivery for students with emotional and behavioral disabilities (EBD). Along with the commitment to fund the operation of the projects, ISBE funded an evaluation of the projects.

Return to Top

Methodology

The evaluation of the EBD Partnership Initiatives is a longitudinal study of the effects of the individual supports and services on student, family and system outcomes. Various instruments were used to collect information on demographic characteristics, family functioning, parent satisfaction, student emotional and behavioral functioning, academic performance and school placements, out-of-home care and hospitalizations, and service receipt. For the purpose of this paper, five research questions were addressed.

1. Did family functioning improve during the course of project participation?
2. What factors were associated with parent satisfaction?
3. Did student functioning improve during the course of project participation?
4. Did out-of-home care change with respect to the number of days and level of restrictiveness?
5. How were local educational systems affected by the wraparound initiatives and what was their impact on local systems of care?

Sample Characteristics

Base-line data were collected on 81 students who were referred for services from September, 1993 through June, 1994. Students were predominately male (82%) with an average age of 14.64 years, ranging from 7.9 to 19.3 years. At the time of referral, 59% of the students scored in the clinical range on Internalizing Behavior and 50% scored in the clinical range on Externalizing Behavior as measured by the Children Behavior Checklist (CBCL; Achenbach, 1991). Forty-one of the students (51%) had at least one out-of-home placement prior to project participation.

With respect to family characteristics, slightly more than half (55%) of the families were two parent households. The majority of families were Caucasian (85%), followed by nine families who were African-American (11%). The average family income was $26,853.00.

Return to Top

Results

The first year evaluation results of school-based wraparound initiatives in Illinois demonstrated positive outcomes; however, these outcomes should be viewed with caution for two reasons. First, they represent findings from the first year of program participation and as yet sustained results have not been measured. Second, Time 2 data was not completed for every student. Preliminary analyses were conducted to test for selection bias. No differences were found between students with Time 2 data vs. students without Time 2 data. The tables in this summary reflect the sample number for each instrument.

Family Functioning

Family functioning was measured using the Family Adaptability and Cohesiveness Evaluation Scales (FACES: III; Olson, Portner & Lavee, 1983). Families completed these instruments at the time of referral and approximately one year after services began (see Table 1). Families who received wraparound services showed a significant improvement in adaptability and cohesiveness.

Family Satisfaction.

Family satisfaction was measured using nine items on the Time 2 Parent Survey. Families were asked to rank items addressing such issues as how the project improved family life, increased their ability to care for their child, and getting to know other parents. An overall satisfaction score was summed across the nine items. The results indicate that satisfaction with the project was associated with parent(s)' perception of inclusion in the decision making process regardless of the specific services that they received. With respect to new services, a positive correlation (r = .44*) was found with family satisfaction and assistance from project staff in obtaining government benefits (e.g., AFDC, SSI, Food Stamps).

Student Functioning

Emotional and behavioral functioning was measured using three instruments: the Children Behavior Checklist (CBCL), the Child and Adolescent Functioning Assessment Scales (CAFAS; Hodges, 1990), and the Teacher Report Form (TRF; Achenbach, 1991). All three instruments were completed at the time of referral and approximately 1 year later. No significant change was found from the TRF. Table 2 gives the results from paired t-tests for males and females from the CBCL. The results indicate that the females students showed significant improvements in Internalizing Behavior. Specifically, improvements were seen in the Withdrawn and Attention Sub-scales of the CBCL. Male students showed significant improvements on the Social Problem and Thought Problem sub-scales. Table 3 gives the results of paired t-tests for the sub-scales of the CAFAS. The results indicate that students who received individual supports and services through the Emotional and Behavioral Disability Partnership Initiatives improved in Role Performance and Moods as measured by CAFAS.

Out-of-Home Care

Out-of-home care was monitored using the Restrictiveness of Living Environment Scales (ROLES; Hawkins, Almeida, Fabry & Reitz, 1992). The instrument was completed at time of referral and 1 year after participation in the project (see Table 3). Students receiving wraparound plans had fewer out-of-home placements and spent fewer days in psychiatric hospitals after receiving wraparound services.

Impact on Local Educational Systems and Service Systems

A self-evaluation tool was developed for project staff to examine their progress relative to specific target goals. These goals adhere to the basic system of care principles. It is believed that the way services are delivered, and the organization of services within the services system, are beginning to be more responsive to the individual needs of students with EBD and their families. Listed below are strategies developed and implemented by project staff to further their system change outcomes.

- Increase parental input in decision making role. Work with state level Illinois Federation of Families to train parents as facilitators. Develop forums (group meetings/support groups) where parents can exchange information and gain advocacy skills.
- Merge project staff positions with special education districts or community agencies to continue to facilitate the wraparound approach (i.e., school social worker&shyp;family service facilitator).
- Merge project interagency councils with the Local Area Networks (LANs). (LANs is a mental health reform in Illinois bringing individualized care services to children with EBD and their families to their communities.)

Return to Top

Discussion

Historically, the education system has been more reluctant than mental health and child welfare systems to incorporate the wraparound tenets into their daily practice. This reluctance clusters around three main concerns. At the school level, is the teachers' receptivity to implement strategies and interventions needed to assist students in more inclusive settings (Clarke, Schaefer, Burchard & Welkowitz, 1992). At the administrative level, is the concern about liability and fiscal responsibility for providing the full array of life domain services identified in wraparound plans. And, at the community level, is the concern about the tension among interagency teams and who should coordinate and implement the plans (Lourie, 1994). These issues create challenges for the comprehensive and sometimes nontraditional aspects of wraparound in the educational system.

The findings from the evaluation of the Illinois Emotional and Behavioral Disability Partnership Initiatives begin to demonstrate how the wraparound process can be an effective means to serve students in school environments. The education system is a natural point of entry for children with EBD and they are in a position to develop partnerships with families and community stakeholders. Improvements in family and student outcomes, as well as the reduced need for psychiatric hospitalizations were demonstrated. Finally, project staff believe that the implementation of this project and approach has changed the larger system of service delivery in these schools and this impact may last beyond any artificial boundaries of the life of a project.

Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

Table 1
Return to Top

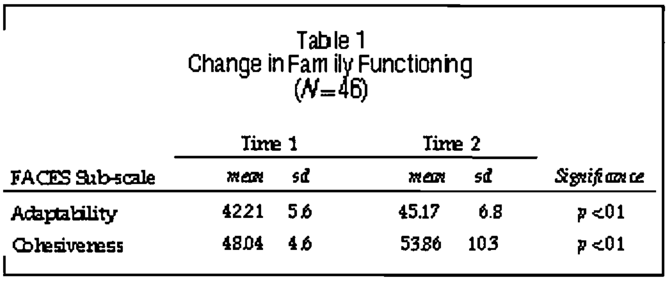

Table 1
Change in Family Functioning
(N=46)

FACES Sub-scale	Time 1		Time 2		Significance
	mean	*sd*	*mean*	*sd*	
Adaptability	42.21	5.6	45.17	6.8	$p < .01$
Cohesiveness	48.04	4.6	53.86	10.3	$p < .01$

[Home] [Search] [Index]

Table 2

Return to Article

Change in CBCL Scores from Time 1 to Time 2 by Gender

	Time 1		Time 2		
Subscores	*mean*	*sd*	*mean*	*sd*	*p*
Withdrawn					
Males ($n = 19$)	5.1	280	42	289	45
Females ($n = 5$)	68	2.16	38	2.16	.03*
Somatic					
Males	2.1	263	15	183	28
Females	30	173	14	151	.18
Depressed					
Males	93	564	72	482	.14
Females	112	349	60	187	07
Social Problems					
Males	62	385	44	361	.04*
Females	58	277	48	178	35
Thought Problems					
Males	28	203	18	203	.01*
Females	26	207	20	122	30
Attention Problems					
Males	10.1	4.40	8.1	453	08
Females	112	277	68	3.19	01
Delinquency					
Males	73	348	76	455	71
Females	76	450	44	550	.14
Aggression					
Males	193	878	162	920	07
Females	218	1080	136	950	06
Internalizing					
Males	157	8.46	124	675	.12
Females	198	521	104	357	.05*
Externalizing					
Males	266	1077	239	1179	21
Females	294	1504	150	1476	07

[Home] [Search] [Index]

Table 3

Return to Article

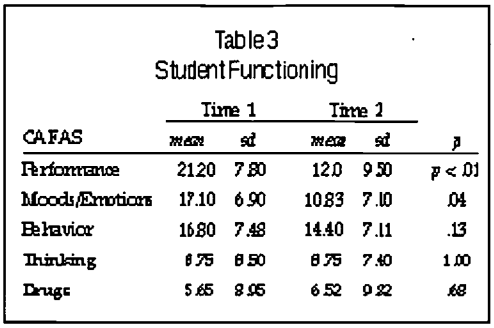

Table 3
Student Functioning

	Time 1		Time 2		
CAFAS	*mean*	*sd*	*mean*	*sd*	*p*
Performance	21.20	7.80	12.0	9.50	$p < .01$
Moods/Emotions	17.10	6.90	10.83	7.10	.04
Behavior	16.80	7.48	14.40	7.11	.13
Thinking	8.75	8.50	8.75	7.40	1.00
Drugs	5.65	8.95	6.52	9.22	.68

[Home] [Search] [Index]

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Florida Mental Health Institute, University of South Florida,1996

Identification of Students with SED: Correlates of State Child-Count Data

Authors

Introduction Method Results Discussion References
Return to Table of Contents

Introduction

The rate at which schools identify children as having serious emotional disturbances (SED) for the purpose of special education has been the subject of considerable controversy in recent years. The national rate (.89% of enrollment) represents roughly one-third to one-half of the estimated prevalence of children with emotional problems who need special education services (Institute of Medicine, 1989; U.S. Department of Education, 1994). This rate has remained quite stable since the national child count data was first collected and has been widely interpreted to mean that, in general, children with SED are significantly underidentified.

The national figure, however, does not tell the whole story. There is substantial variation across states in the rate of identification, ranging from .04 % to 2.15% of enrollment for the 1991-92 school year. This 50-fold difference between the lowest and highest rates suggests that states are identifying and serving children with emotional disturbances very differently. While the highest rate states fall within the estimated prevalence range (2-3%), most states fall well below these figures (U.S. Department of Education, 1994).

The present study examines relationships among state SED identification rates and a variety of economic and demographic variables. The purpose of these analyses was to investigate variables which may be relevant in predicting, planning for, and influencing state identification rates for children with SED. At a broader level, we examine the public policy implications of these relationships and describe further investigation which will clarify the picture.

Return to Top

Method

State identification rates for children with SED for 1992 were calculated from the national dataset used to produce the annual report to Congress. This dataset includes the number of children identified with SED in the public school system in each of the 50 states and the District of Columbia, as well as estimated enrollment figures for each state. The identification rates that were used are identical to those published in the Fifteenth Annual Report, within the limits of rounding error, except for isolated cases in which the figures were updated after the Annual Report went to print (U.S. Department of Education, 1993). For the present analyses, we used the ratio of the SED child count to the estimated enrollment for each state (SEDRATE).

Economic and demographic variables were extracted from the National Center for Educational Statistics, summarizing information relevant to education. On the basis of previous related work, we selected a set of economic and demographic variables judged likely to relate to the identification of SED children.

State demographic variables included geographic region, using NCES regional divisions (REGION); state per capita income (PERCAP); state per pupil revenue (PERPUP); and a ratio of per pupil revenue to per capita income (INDEX). According to the Education Digest, INDEX "reflects monies raised to educate the average public school student relative to the taxpayer's ability to pay" (National Center for Education Statistics, 1992). The primary race variable (WHITE) represented the percent of Caucasian students enrolled in public elementary and secondary schools in 1990. It should be emphasized that this distribution was for the public school population as a whole, not the ethnic distribution of the special education population, wherein minorities are often overrepresented. Finally, as a relative measure of school achievement level in the state, eighth grade math proficiency scores (MATHACH) were included in the variable set.

State economic variables included in the analyses were: (a) Total Expenditures Per Capita (TEPC), which consisted of state and local government expenditures for education services, social services and income maintenance, transportation, public safety, environment and housing, governmental administration, interest on general debt, and other general expenditures, including intergovernmental expenditure to the Federal Government; (b) Education Expenditure Per Capital (EEPC), which reflected state and local government expenditure on all education ; and (c) Elementary and Secondary Education Expenditure Per Capita (ESEEPC), representing state and local government expenditure on elementary and secondary education.

Elementary and Secondary Education Expenditure Per Capita figures, per pupil revenue, and per capita income figures were ranked and then converted to quartiles for the purposes of the ANOVAs reported below. In each case, the first quartile represents the states with the lowest incomes or expenditures while the fourth quartile represents the states with the highest. Regional divisions, expenditure per capita quartiles (EXPQRT), per pupil revenue quartiles (PRPQRT), and per capita income quartiles (PCIQRT) were compared in separate ANOVAs to examine the effects of these variables on SEDRATE. Correlation analyses were conducted to explore other relationships among the variables. A stepwise regression was performed, including all variables which displayed moderate relationships ($r > .30$) with SEDRATE. Finally, the earlier ANOVAs were run again, using as covariates those variables which entered into the stepwise regression to determine which variable possessed the best predictive value.

Return to Top

Results

SEDRATE was found to differ significantly across regions ($F = 6.47$; $p = .0009$). A Student-Newman-Keuls (SNK) means comparison revealed that Northeast states have significantly higher rates of SED identification than Midwestern, Southern, or Western states. The latter three do not differ from one another.

SEDRATE also differed across expenditure quartiles ($F = 4.09$; $p = .01$). The SNK test indicated that states spending the least on elementary and secondary education per capita (EXPQRT = 1) identify significantly fewer SED children. Quartile 2,3, and 4 did not differ on SEDRATE.
Per pupil revenue quartiles differed significantly in SEDRATE ($F = 5.56$; $p = .0024$). SNK means comparisons revealed that states with the highest per pupil revenue (PERPUP = 4) had higher rates of SED identification than states in quartiles one and two. States in the third quartile also had higher rates than states in quartile one.

The per capita income quartiles ANOVA also yielded a marginally significant effect ($F = 2.95$; $p = .04$). The SNK means comparison did not reveal significant differences among the means, although there was an orderly trend from the lowest per capita income states (PCIQRT = 1; SEDRATE = .57) to the highest (PCIQRT = 4; SEDRATE = 1.05).

The correlation analysis revealed three variables that were moderately related and positively related to SEDRATE: per pupil educational revenue (PERPUP; $r = .49$), per capita income (PERCAP; $r = .46$), and the NCES Index (INDEX; $r = .31$). No other significant correlations were found.
The stepwise regression procedure yielded a single variable in the final equation (PERPUP). The model

R-square was .24, indicating that about one-fourth of the variation in SED identification rate can accounted for by variation in the amount of educational revenue per pupil in the state.

The REGION ANCOVA with per pupil revenue as a covariate yielded a marginally significant regional effect (F = 2.53; p = .07). Comparison of adjusted least squares means indicated that Northeastern states continue to show higher identification rates than Southern and Western states; no other comparisons were significant.

The EXPQRT ANCOVA with per pupil revenue as a covariate also yielded a marginally significant effect (F = 2.56; p = .07). Comparison of adjusted least squares means revealed that the states in the first quartile (i.e., lowest expenditures) identify significantly fewer SED students than states in the second quartile (p = .02) and states in the fourth quartile (i.e., highest expenditures) identify marginally significantly fewer SED students than states in the second quartile (p = .06). Other comparisons were not significant.

The PCIQRT ANCOVA with per pupil revenue as a covariate did not yield a significant per capita income quartile effect.

Return to Top

Discussion

Examination of the correlates of states' SED identification rates reveals that demographic and economic differences across the country may play role in the identification process. While these relationships do not explain the variation in SEDRATE, they point to some factors that may play a role in that variation.

While per pupil revenue is the strongest (and the only significant) single predictor of SED identification rates, it accounts for relatively little of the state variation. Further, when the effects of per pupil revenue variation are removed, states continue to show marginally significant effects for region and expenditure on elementary and secondary education.

While the significant effects of economic variables suggest that educational revenue is important, there are clearly other variables not included in the present analysis which also contribute to the range in SED identification rates. The continuing regional differences may indicate the need to examine social and political characteristics of states in order to better understand that variation.

It is perhaps equally illuminating to consider those characteristics of states which did not relate to the target variable. Size of the state, racial makeup (percent White), expenditures on human services, and achievement measures were all unrelated to the rate of identification of students with SED. These features which are sometimes thought to be associated with prevalence of SED are either unrelated or their relationship is masked by other contravening effects.

In sum, the present analyses offer some indications of the source of the variation in identification of SED students and hint at the significance of other constructs not included in the study. Further investigation, following the directions suggested above, is warranted to better understand how states identify children with emotional disturbance.

Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

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Comparison of Children and Adolescents with Serious Emotional Disturbance Served in Hospital and in School

Authors

Introduction Method Results Discussion References
Return to Table of Contents

Introduction

This paper used administrative data to compare the characteristics of children and adolescents with SED from an urban county who were hospitalized in a regional state mental hospital with those of youth placed in special educational settings. This study also examined the array of public sector mental health services provided to these youths prior to their hospitalization or placement. The questions surrounding this investigation included:

- How likely is it for children who were hospitalized for SED to have received services in the special educational system during a previous school year?
- Are children who are treated in a state psychiatric hospital more likely to receive ambulatory treatment than children who receive special educational interventions for SED?
- What demographic and risk factors may differentiate between children and adolescents served in the two service systems?

Return to Top

Method

Data Sources

Data for this study came from large client-specific data sets for the 1991-1992 fiscal year. Mental health services information was extracted from Medicaid paid claims for inpatient, outpatient, and partial hospitalization for all eligible beneficiaries in a large northeastern city; from the county reporting system for recipients of specialty mental health services in the public sector; and from the regional state mental hospital (SMH). Each of these databases was limited to the 1992 fiscal year and to county residents. There were 10,942 MA records, 8391 county records, and 101 state mental hospital records.

The State Bureau of Education provided statewide data on children identified as having a serious emotional disturbance as prescribed in P.L. 94-142 and its amendments, or children placed in emotional support classrooms. These records, which were entered directly on site when Individual Educational Plans (IEPs) were submitted for the annual head count, contained demographic and placement information, including services received, location of intervention, percentage of time in special setting, and suspensions from school. In 1992 there were 24,437 records for the entire state, and 3433 for the county under study.

Analyses

Each of the Medicaid-reimbursed claims was identified by a sixteen-digit recipient code, assigned at the time of first request for approval of service. These numbers were issued sequentially by the Office of Medical Assistance. County mental health records carried a unique nine-digit client-specific eligibility number. In the state mental hospital records, eight-character facility-specific case numbers were assigned to each patient, and social security numbers were also available on some client files. Special education (BSE) records contained an identification number constructed of the nine-digit administrative unit number which represented the school where the child's IEP was implemented, and up to nine more digits identifying the individual learner. However, except for the county mental health record numbers, which were less subject to change, none of these identifiers was unique and truly client-specific. Movement from one SMH inpatient facility to another or from one BSE setting to another, led to the attribution of a new and unrelated case number. Consequently, any individual receiving multiple services in the public sector could have been identified with several codes within and between service provider agencies.

In order to merge the data and determine an unduplicated count of children who received multiple services, and what array of services they received, all the while protecting confidentiality, an identifier was constructed of patient initials, birthdate and sex, using an algorithm comparable to those described elsewhere (Donaldson & Lohr, 1994; Goerge, Van Voorhis, & Lee, 1994). Successive sorting and merging of the data yielded a pool of 26,954 individuals. This pool represented about 8.7% of the county population for this age group (uncorrected 1990 U.S. Census count for children aged 3-17 in Urban County = 309,712). Descriptive analyses of socio-demographic and risk factors for the hospitalized and school-identified children were performed. Odds ratios and their confidence intervals were calculated to compare the special education and psychiatric inpatient service systems (Kahn & Sempos, 1989).

Return to Top

Results

Descriptive Analysis

There were 797 children and adolescents who received inpatient psychiatric care in the county, and 3,433 who had an IEP during the 1992 fiscal year. There was a majority of male youth in both inpatient mental health and special education, but the ratio of males to females in special education (4:1) was much higher. The mean age of children receiving special educational services was 12.7 years (SD = 2.9); mean age of inpatients was 12.8 years (SD = 3.1), and those in the regional state mental hospital was 14.3 years (SD = 2.1). Special education and community-based mental health services served a proportion of minority clients which was consistent with local demographics, but inpatient facilities served a much lower proportion of minority clients.

Of the 797 inpatient psychiatric clients, 101 were hospitalized in the regional SMH for children and adolescents. Twenty-nine percent of these patients had been hospitalized in a community psychiatric unit prior to transfer to the state hospital, for lengths of stay ranging from one day to more than six weeks; more than half of these prior hospitalizations had been billed as emergency interventions. More than half SMH youth (60%) had received community-based outpatient services in 1992, and 5% had also been served in partial hospitalization. Fifteen percent received intensive case management and four patients had also received "wraparound" mental health services in their homes or communities. Only four patients had been identified as SED in the schools prior to their inpatient stay. The majority of these patients (70%) were Medicaid eligible. Except for gender (100% male) and race (84% African American or Latino), the 26 youth who were admitted to the state facility from correctional facilities were comparable to the hospital population (28% prior hospitalization, of which 60% were emergency).

Of the 3,332 youth with active IEPs who were not in the SMH, one third received mental health services in 1992. Of these 3% had an inpatient psychiatric stay in the community (85% of which were billed as emergency admissions), 17% received outpatient treatment (mean = 76 units, SD = 135 units), and 4% also had partial hospital treatment (mean = 20 units, SD = 47 units). One out of five of these youth lived in a state or private institution and 3% lived in correctional facilities. About two-thirds of children and adolescents with SED spent more than 60% of their day in a BSE setting, and were therefore separated from their agemates; 25% were not in their home school and were therefore separated from their neighbors. Eighty-two percent of those who spent more than half their school day in a separate placement were male, as were 86% of those who were suspended at least once; 80% of those who were suspended were African American or Latino youth. Nearly half (44%) of those in special education in 1992 had been referred for evaluation prior to 1985, and 5% had received inpatient mental services in community-based facilities prior to 1992.

Odds ratios (OR) and their 95% confidence intervals (CI) were calculated to test for reliable differences between youth served in these two service systems. Of those who received mental health services in the community in 1992, children who were hospitalized in the regional SMH were almost six times as likely as those in BSE to have received outpatient services in 1992 (OR = 5.9 ; CI 4.1, 8.6). Three percent of SMH patients and one percent of children receiving BSE services also received inpatient services in FY 1992, and there was no difference in the rates of partial hospitalization (about 4%) between the two groups. African American and Latino youth were more likely than Euro-American youth to receive only BSE services (OR = 1.6, CI 1.4, 1.9); Euro-American children were twice as likely as African American and Latino youth to receive BSE services in an institutional setting (OR = 2.2; CI 1.8, 2.6), and about twice as likely to receive community-based inpatient psychiatric services (OR = 2.0; CI 1.6, 2.4). Euro-American youth were marginally more likely to receive mental health treatment in the SMH (OR = 1.5; CI 1, 2.3), but African American and Latino youth were more likely to be in the forensic unit of the SMH (OR = 3.5; CI = 1,11).

Return to Top

Summary and Conclusions

Integration of data sets from several service systems for children with serious emotional disturbance served in the public sector of an urban county yielded records for about 8.7% of the child and adolescent population. The current study sought to identify differences in demographic patterns and levels of care within and between state psychiatric hospital and special education service systems. Descriptive analysis of recipients of these two services for children revealed few system-specific differences: both represented greater than 70% male and 70% or more African American and Latino youth; 70% of the state hospital population was Medicaid eligible. State hospital patients tended to be slightly older than children served in special education; youth in forensic placements in the SMH were older. Youth in more restrictive placements in both service systems were disproportionately male (82% to 100%) and African American or Latino (80% to 84%).

The greatest contrast between the systems was the proportion of children who received other mental health services during the 1992 fiscal year: 64% of those in the SMH received other mental health services (particularly outpatient treatment) during the year, compared to about one-third of youth in SED placement in the BSE system. It was quite unlikely for children hospitalized in the state psychiatry facility to have been placed in SED special education services prior to hospitalization; this suggests that these patients were functioning adequately in the school setting, that their behaviors were not disruptive in spite of their serious emotional disturbance, or that their emotional and psychiatric needs otherwise went unnoticed in the classroom. This issue deserves further research.

Developing integrated service system data sets like the one described here and in Goerge, Van Voorhis and Lee (1994) is a labor-intensive undertaking, but one that produces an invaluable resource for program planners and service researchers. Analysis of the unduplicated count of recipients across service systems can assist in identifying trends in service delivery, patterns of cross-system communication, and dimensions of risk factors and resilience in the community.

Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

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One Year Outcome Findings of the Vanderbilt School-Based Counseling Evaluation Project

Authors

Introduction Method Results Discussion References
Return to Table of Contents

Introduction

The Vanderbilt University School-Based Counseling Evaluation Project (SBCEP) is a federally funded, children's mental health services research program designed to evaluate the effectiveness of a collaborative in-school counseling program relative to a tutoring program and traditional community based services. Our program addresses four primary areas: (1) the early identification of disturbance in at-risk youngsters; (2) the relative accessibility and utilization of psychological services; (3) the prevention of costly and restrictive placements; and (4) the effects on students' adjustment.

Estimates of psychological and behavioral disturbance among children from socially and economically disadvantaged backgrounds are overwhelming. Unfortunately, these at-risk youngsters often do not receive needed psychological resources, whether it be due to a lack of appropriate and accessible mental health services, or because their families lack the transportation or finances necessary to obtain treatment.

This evaluation project was grounded in pilot work demonstrating the feasibility of executing a collaborative system of care between mental health and school personnel in the school setting. In our school-based programs, qualified, trained and licensed mental health clinicians provided a range of services to youngsters at school. The Vanderbilt school-based counseling programs first were established in three pilot schools and provided comprehensive mental health services to youngsters referred by their classroom teachers. Teacher, principal and parent anecdotal report, together with clinical observation, suggested the programs were successful. In light of the recent political and economic climate of decreasing availability of funds for non-traditional mental health services, a systematic evaluation of the effectiveness of the program was proposed. The SBCEP represented an experimentally controlled effort to demonstrate the impact of school-based services on service use, accessibility, and children's mental health.

Return to Top

Method

Nine Metropolitan Nashville schools were selected and invited to participate in the research. Three schools served as comparison sites, with 30 - 40 youngsters from each school referred for traditional, community-based, out-patient treatment; and six were treatment sites, with 30 - 40 children from each school randomly assigned to receive either school-based counseling (SBC) or academic tutoring (AT). These groups allowed us to experimentally determine the effectiveness of our school-based counseling services.

In all schools, youngsters were selected for participation based on a set of multi-informant indicators of psychological adjustment. Based on research suggesting that child self-report and teacher referrals may

overemphasize certain problems and underemphasize others, student selection was based on school-wide mental health screenings conducted with children, their peers, and teachers.
These assessments consisted of a series of mental health measures and were administered twice yearly. Specifically, measures were selected/designed to tap six domains of psychopathology, including: delinquency, aggression, hyperactivity, depression, anxiety, and somatization. Reports from each informant were weighted based on the relative validity of specific informants' reports when considering a particular area of psychopathology. What results from this combination of informants and weighting of scores is a total psychopathology score which allows us to select children representing a broad range of emotional and behavioral disturbances. Concurrence among at least two reporters was a necessary condition for participant selection. Therefore, if a youngster self reported very high levels of depression but the report is not confirmed by teacher or peer report, that child was not selected. A score of at least one standard deviation above the mean was required in order to be considered eligible for enrollment.

In addition to a total psychopathology score, data from these school-wide screenings were used to determine a particular child's primary problem area, the domain of psychopathology where difficulties were most severe. A number of our analyses were centered around this primary problem domain because we hypothesized that improvement in functioning would be most evident when a child's most serious emotional or behavioral problem was considered. Also, for each child identified, we determined a secondary problem area which represented scores on the domain of psychopathology for which they received the second highest score.

Our program also included a family interview prior to enrollment. Therefore, for each child, we had teacher, self, peer and parent report of adjustment over time. For the most part, we considered the weighted sum of the school informants together, given their similar context, and the parent report as a separate score.

Students were in the 2nd to 5th grades at the time of our initial assessment (Spring 1993). They ranged in age from 7 to 14, with a mean age of about 10 years, and about 63 % were from minority backgrounds. Greater than 70% of the students enrolled in these urban schools received free school lunches, an indication of the level of poverty. Over 20% of students in these public schools evidenced serious behavioral and emotional problems. Based on our home interviews, it was evident that the families and children we treated would not be receiving consistent mental health services if not for our program.

Counseling services were provided at school, during regular school hours. They were comprehensive, and could include combinations of individual, group, parent treatment, family therapy, teacher consultation, and psychiatric consultation&shyp;in fact, any services traditionally found at local community mental health centers. Some of the strengths of having a school-based counselor included:

- accessibility for consultation with teachers regarding classroom management; opportunities for immediate feedback regarding behavior management strategies;
- readily accessible observation of youngsters in structured and unstructured settings;
- more realistic understanding of child's academic environment;
- ability to educate teachers regarding the kind of information that is most useful in developing a treatment plan;
- immediate accessibility;
- school as a safe place fostering parent/family involvement in treatment;
- availability for participation in school team meetings;
- ability to provide teachers with a different perspective on students;

- early identification of student difficulties, ability to teach school personnel to recognize early indicators of maladjustment;
- more consistent treatment participation; and
- ability to support school-wide curriculum for school-wide impact (e.g., anti-drug use programs, anti-violence programs).

In regards to psychopathology, our outcome measures could be placed into one of four groups:

1. Primary Problem Domain, which, as mentioned earlier, represents the problem area for which a child received the highest rating prior to services. Thus, for one child this variable might represent a standardized depression score, whereas for another child it might represent an aggression score;
2. Total Problem Score, which represents the sum of the various measures, across all domains;
3. Internalizing Problems, which include depression, anxiety, and somatization; and
4. Externalizing Problems, which represent aggression, delinquency, and hyperactivity.

These outcome measures also were grouped by informant, including: Teacher, Self-Report, Peer, and Parent.

These were our dependent variables. All analyses compared the functioning of our Counseling versus Tutoring children at the end of the first academic year of services, adjusting for their functioning at the beginning of the year. The primary independent variable was Group, which was the Counseling versus Tutoring comparison. However, we also were interested in the relation between outcome and several other factors: We were interested in whether treatment was more effective: (1) with girls versus boys; (2) with older versus younger children; and (3) with children whose primary problem area was Internalizing Problems versus children whose primary problem area was Externalizing Problems. So we tested the interaction of each of these effects with Group measures.

Return to Top

Results

It was the Primary Problem Area which we believed would be the most likely to change as a result of our intervention. When parent report of a child's primary problem area was considered as the outcome criterion, our data revealed no significant differences between AT and SBC children. In fact, when we controlled for the level of disturbance prior to our intervention, a trend emerged for students enrolled in SBC to do marginally worse than those youngsters enrolled in AT. This finding is consistent with previous research from Weisz and Weiss who found that 6 months following service provision, parents of children in the control group reported no significant improvement over children in the treatment group.

Similarly, a trend was evident in parents' reports of their children's social strengths: Although nonsignificant, parents' report of students enrolled in AT indicated marginally greater social competence than students receiving SBC at the end of one year of treatment. When parents' reports on the CBCL TOTAL scores were considered, the trend for greater improvement in functioning again favored AT children over SBC children. When scores for internalizing and externalizing difficulties were analyzed separately, however, this trend disappeared.

When we looked more closely at children's primary problem areas, grouping them according to whether they represented externalizing behavioral problems or internalizing difficulties, a significant Group x Primary Problem Area interaction emerged. Specifically, for children with internalizing problems (i.e., depression, anxiety, somatic complaints), enrollment in SBC resulted in more gains in parent reported social skills, whereas for children with externalizing problems (i.e., delinquency, hyperactivity, aggression), the opposite was true; students enrolled in AT scored better on measures of social skills.

The combined, total psychopathology scores from teacher, self and peer ratings revealed no significant differences or trends for AT and SBC children with respect to primary problem domain. Also, when considered independently, analyses of teacher and peer report did not reveal differences in primary problem domain based on group (AT or SBC). Analysis of children's self-reported level of adjustment, however, revealed a significant interaction between type of intervention (AT or SBC) and type of primary and secondary problem areas. Specifically, children who had Internalizing Problems as their primary and secondary problem areas reported similar gains in functioning, whether enrolled in AT or SBC. However, students evidencing primary and secondary symptoms of externalizing disorders made significantly more gains in self-reported adjustment when enrolled in SBC than when offered AT. Additionally, students with primary and secondary problem areas representing characteristics of both internalizing and externalizing difficulties made greater gains in AT than SBC services.

Finally, we examined gender and age differences in our data. No evidence for Sex x Group interactions emerged. However, our data revealed a significant Age x Group interaction which suggests that children 10 years and under, but not adolescents, enrolled in AT report greater improvement in functioning than children in SBC.

Return to Top

Implications

These data represent a small part of the big picture of the School-Based Counseling Project. We've focused exclusively on our psychopathology outcome measures. Some trends suggest improvement, while other findings highlight the lack of differences. These data were consistent with naturalistic assessments of children's mental health services documenting little change in targeted behaviors. One year of service provision might not be enough, given the severity of these children's problems. Perhaps findings after two years of intervention will provide a more positive picture.

In addition to psychopathology indicators, we will examine school-wide indicators of adjustment (e.g., grades, disciplinary measures, absences, restrictive educational placements) which may be linked in important way to the availability of an on-site mental health counselor. We will also scrutinize the activities of our school-based counselors. For example, some clinicians favor a more cognitive behavioral style, others favor a more play-therapy focus to treatment; some more actively consult with school personnel, where others work more exclusively with the children.

Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

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Interagency Collaboration Efforts with Families with Severe School Refusal Problems

Authors

Introduction Method Results Discussion References
Return to Table of Contents

Introduction/Purpose

The research demonstration project, Outcomes of Parent- and Provider-Designed Systems of Care (CMHS 5HD5SM50736), is discussed in detail in Armstrong, Evans, Tannen, and Scudder (1995) and in Evans, Armstrong, Thompson, and Lee (1994). Two rural counties in upstate New York have been provided equal funding to compare the processes and outcomes of systems enhancements based on very different principles. In Essex County, the naturally occurring experiment of Families First provides a demonstration of the principle of parent involvement taken to its logical conclusion, being an organization designed to build a partnership between families and professionals and to develop services which respond to families stated needs. Herkimer County, on the other hand, has developed a provider-designed, school-based, family-therapy enhancement to their mental health services for children.

Families First under the guidance of Naomi Tannen, its director, has been providing a broad range of services to the community for over two years. Services include phone support, resource library, respite, financial and transportation assistance, trainings and workshops, and social events. Families First employs two half-time Intensive Case Managers (ICM) who also work as family advocates, and a home-care provider. In addition, many parents are employed in a wide range of roles. Families First is constantly working at both the case level and the county administrative level to convince other agencies to involve families in decision-making, with varying levels of success. The research discussed in this presentation provides detailed examples of this work.

Return to Top

Method/Procedures

Three methodological approaches are being used to assess the processes and outcomes in the two counties: a treatment outcome study, a network analysis study and a combination of qualitative methodologies. The qualitative research presented here was conducted in Essex County by the first author, and involved comparing two service participants' experiences in order to explore Families First's progress in family involvement and interagency collaboration. These histories provide examples of the practical ways in which agencies choose or are required to work with each other, often requiring face-to-face discussions and documentation in which opinions are openly expressed. By looking at interagency collaboration, we can assess the position of agencies vis-á-vis Families First as this new agency seeks to insert itself into the traditional system of agencies and as it seeks to change the attitudes and behaviors of those entrenched agencies.

Severe school refusal was chosen for this study from the various problems of the more than 30 children and families helped by Families First's ICM program, because, almost uniquely, clarity of assessment of successful treatment is possible: the youth returns to daily school attendance. The two families were selected because both the students, Christie and Darlene (pseudonyms), and their family situations had strong similarities, because they were introduced to Families First at approximately the same time, and because their experiences of the system of care were very different.

In-person, in-depth interviews were conducted with family members, with the Intensive Case Manager, and with many other service providers and administrators, as well as through phone conversations. Meetings at Families First and conversations with staff members kept the researcher abreast of developments. Where Darlene was concerned, interagency meetings and a court hearing were observed. Documentation was gathered from many sources.

Two Cases Of Severe School Refusal

Christie's and Darlene's circumstances had much in common superficially. Christie was 12 and Darlene 14. Both lived in small family units in rural towns with large extended families close by. They were academically successful when attending school. Both not only refused verbally to go to school but fought violently not to be taken inside, and were out of school almost every day of fall 1993. Both schools were obliged to file a PINS petition or be able to show reason for not doing so. Both families were reported for child abuse by neighbors who saw that the girls were not going to school and that furious arguments were going on. Both mothers blamed themselves in part for the defiant behavior. Darlene's family seemed to have more social and cultural capital (Bourdieu, 1986) than did Christie's. Darlene's mother had been a foster mother for seven years. Her older sister had been a model student. Though never having lived with them, Darlene's father maintained a positive supportive relationship with Darlene and her mother. A retired corrections officer and successful business owner, his two sons were high-school graduates. Realizing the school avoidance problem was too much for her, Darlene's mother drew on her connections in the town and the county for help, to get Darlene to school, and to get a psychiatric evaluation and appropriate treatment.

Christie's family, on the other hand, was under great stress: relatives' illnesses, their recent moving, and her father's unemployment and protracted workman's compensation case. They had no parent/child roles and no family routine. Christie's parents had become as physically withdrawn as Christie and rarely left the house. Neither parent had much schooling. There was little contact with the community outside the extended family.

Parent Involvement and Interagency Collaboration Efforts

The school referred Christie and her family to the mental health clinic, whose staff introduced them to Families First. Families First and the school psychologist convinced the principal and school board of a psychiatric problem, providing time for evaluation by a psychiatrist and for modeling of normal parent/child roles and routines by Families First's home-care provider. When Child Protective Services were called in, they agreed an evaluation was needed and agreed to split the costs with the school and Families First. The psychiatrist found by the school psychologist was respectful of and encouraging to Christie's family; her practical recommendations laid the groundwork for a treatment plan designed collectively by family members and agencies. Positively-reinforced incremental steps were designed and carefully attended by the ICM and the school psychologist to reintroduce Christie to school, where changes were made to provide welcome and support. Once Christie was established in a school routine, Families First shifted focus to helping her parents become independent of the family. Christie's mother now works as a parent advocate at Families First. Christie went to school all through fall, 1994 and winter, 1995.

Darlene's school had less patience for her resistance to school. Threats of removal from home had succeeded with other students, so they filed a PINS (Person in Need of Supervision) petition in October 1993 which led to a court-ordered 30-day residential evaluation and the shifting of Darlene's custody from her mother to Social Services. Darlene's mother's prior requests for help from Social Services, with whom she had worked as a foster parent, fell on deaf ears. The evaluation blamed the parents and recommended long-term residential treatment. Families First became involved while the family appealed, working with Darlene's family and the school to implement a desensitization treatment plan, made in collaboration with a child psychologist, an expert on school refusal, hired by Families First. Having made curriculum changes, the school had little tolerance for less than total attendance. Darlene's problems took a toll on Families First: much extra time was needed to talk and meet with lawyers, and to help with violent outbursts at home, as well as the expected difficulties of implementing the treatment plan.

Attendance having been up and down, the court decided that Darlene should live with her father while awaiting residential placement. Darlene's responsible behavior over the summer impressed Families First but not Social Services, who placed her in a facility an hour from home. In September 1994, Darlene revealed she had been sexually assaulted at her home school. For Families First and their consulting psychologist this news explained her school avoidance. Her father increased his efforts with the courts to get her home. But Darlene then became pregnant and this was seen by Social Services as another indication of incompetent parenting. Despite the family's and Families First's efforts to negotiate her return home, Social Services moved Darlene in January to a facility for pregnant girls further from home where education was not a priority, despite its being the motivating factor in the initial placement. Finally, Darlene's father's home was evaluated and in March the court gave custody to her father.

Return to Top

Conclusions

The striking difference between the following descriptions illustrates the gap between alternative solutions to the problem of school phobia. The Social Services lawyer characterized Darlene's family as intergenerationally dysfunctional:

> Her familial history suggests that she will simply be another teenage mother without a high school education, with parents who are dysfunctional, who have raised a dysfunctional child, and now want to help raise a dysfunctional grandchild.

This view of Darlene's family as essentially a bad influence is completely the opposite of the view of the consulting psychologist:

> Darlene has been alienated from her family by the abuse of a stranger and her fear of revealing this secret. It seems to me only a further exacerbation of this wound to keep Darlene, at this point, from her family&shyp; a family who wants to nurture her, by whom she wants to be nurtured, and who, until she was so cruelly and secretly misused, was able to provide her totally adequate care. It is inconceivable to me that she could be transferred to an unfamiliar environment at even greater distance from her home when her parents are so willing to provide for her and her unborn child.

Definition of the problem and the range of possible actions are tightly shaped for service providers by their agency's mandate and history; some agencies welcome family involvement in planning solutions while others do not. Through dealing with Christie's and especially Darlene's problems, Families First has learned much about how to build successful collaborations so that residential placement is agreed to be the last resort.

Some, though not all, of the variables which contributed to the extension of the trials and tribulations of Darlene and her family are related to agency collaboration efforts:

1. Agency knowledge of new services can be important: perhaps ICM may have been too new a concept for Social Services and the judge, and perhaps now Families First and the ICM program will be given a second chance to show what can be accomplished at home. Social Services appears to remain skeptical and further interviews will provide valuable insight into their perspectives.
2. The school's experience will also be telling. School perspectives on school refusal can shape crucial moments, such as non-attendance being considered truancy or an emotional problem.
3. Lawyers' disregarding the importance of interagency collaboration may be detrimental to collaborative efforts when the courts are involved, increasing conflict among involved agencies.
4. Shifts in the personnel can alter the atmosphere: in this case, change of lawyers may have made

things more difficult, change of judges may have facilitated Darlene's going home.

Return to Top

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Return to Top

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Note: Naomi Tannen, founder and Executive Director of Families First, has read and commented upon this paper in draft form, and some of her comments may have been incorporated into the final paper. However, the analysis presented in this paper does not necessarily reflect the views of Naomi Tannen and Families First. The responsibility for the research, the analysis, and the presentation of findings remains with the authors.

Return to Top

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies,
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Day Treatment for Children with Emotional and Behavioral Disorders: A Program Evaluation

Authors

Introduction Method Results Discussion References
Return to Table of Contents

Introduction

This study sought to answer several pertinent questions about the Lincoln Public School (LPS) Behavioral Skills Program (BSP). First, the study looked at whether students referred to BSP exhibited a level of behavioral and emotional problems and experienced levels of psychosocial stressors which was higher than the general population of students with Behavioral Disorders (BD). Second, this study sought to document the outcome of treatment by measurement of change in academic achievement, behavioral assessments, and performance of behavioral goals. Third, this analysis attempted to determine if students in this program had relatively more success in certain types of behavioral goals compared to other types of goals.

Return to Top

Method

Participants

Thirty students identified as having a BD, in grades Kindergarten through 9, enrolled at BSP during the 1993/94 academic year were included as participants in the study. Males made up over 97% of the participant group. Students of European descent made up 68% of the participant population, 24% were of African American decent, and 8% were of Native American heritage. The participants had been unsuccessful in less restrictive treatment alternatives, and 74% had a history of psychiatric hospitalization.

Procedure

The Child Behavior Checklist-Teacher Report Form (CBCL-TRF; Achenbach & Edelbrock, 1991) was completed by home school teachers and BSP teachers at the beginning of the academic year or shortly after admission to determine initial levels of problem behaviors. Total problem scores, as well as externalized and internalized behavior scores, were compared to CBCL-TRF ratings collected by Conoley & Peterson (1989) on a state-wide sample of children verified as BD served in regular schools in Nebraska.

School records, court records and other official documentation were collected to determine the number and type of psychosocial stressors students had experienced. This information was compared to research findings documenting the number of stresses associated with severe maladjustment and with similar data collected from other samples of students with BD in Nebraska and in other published research.

Academic achievement was assessed using a pre-post comparison of performance on the Kaufman Test of Education Achievement-Brief Form (KTEA; Kaufman & Kaufman, 1985) in reading, spelling, mathematics, and composite scores. The test was administered at the beginning of the academic year or shortly after admission and again at the end of the academic year.

Behavioral change was assessed by making a pre-post comparison of CBCL-TRF's completed at the beginning of the school year or shortly after admission and the results of a second set of ratings taken at the end of the academic year by both home school and BSP teachers. Behavioral change was also assessed by tracking the change of three behavioral goals from each participant's Individual Education Plan (IEP). These goals were continually tracked during each class period at BSP. A zero tolerance level was maintained. If the child, at anytime in the class period, did not achieve the goal, it was marked as not successful. Daily averages on these goals were converted to 8 week averages, calculated four times over the course of the school year.

The success students exhibited on the various types of goals was analyzed to determine if there was any differential progress. IEP goals were coded based on a manual of IEP goals used by the Lincoln Public School District. The goal categories included classroom skills, mainstreaming and adjustment, self esteem and self concept, coping skills, peer and adult interactions, and personal responsibility.

Treatment

The Behavioral Skills Program (BSP) is a collaborative program conducted by Lincoln Public Schools and Lincoln/Lancaster Child Guidance Center in operation since 1986. The program provides therapeutic services in home schools and intensive therapy and educational services in a self-contained site that students are bused to daily. Generally, students attend an hour or two a day at the home school and add time as appropriate for the student. The program is designed to focus on academic and behavioral skills development and the treatment of critical mental health issues.

Return to Top

Results

The results of the initial CBCL-TRF and the level of psychosocial stressors BSP students experience indicated that BSP students were significantly more disturbed than the general population of students with BD. When both internalized and externalized ratings were included, 69% of BSP students had behavior problem levels in the clinical range. The CBCL-TRF scores provided by home school and BSP teachers were significantly correlated (.55 -.51).

When compared to scores of a state wide sample of students verified as BD, it was found that BSP students problem behavior ratings were significantly higher. BSP students received a mean total problem score of 68. The mean rating of externalized behaviors for BSP students was 69 and the state wide sample was 60. Internalized behavior scores for BSP students were 64 compared to 50 for the state wide sample (Conoley & Peterson, 1989).

Students served by BSP experienced high levels of psychosocial stressors. Previous research indicates that the presence of 3 psychosocial stress factors put children at risk of severe social maladjustment (Siefer, Sameroff, Baldwin & Baldwin, 1992). The data collected indicated that BSP students experienced a mean of 10.6 psychosocial stress factors. Secondary students (grades 6-9) had a mean of 12 stress factors and elementary students (grades K- 5) had a mean of 9 stress factors.

This study addressed the question whether students at BSP demonstrated significant positive change in academic achievement. Overall, students made significant improvement in all three achievement subtests of reading, spelling, and mathematics, as well as in composite scores. Not only do these results indicate students were maintaining normally expected achievement progress, they were making marked increases in academic achievement. In addition, total risk positively correlated ($r = .45$) with academic achievement test improvement. In other words students entering with high degrees of psychosocial stressors showed the most improvement in academic achievement scores.

The CBCL-TRF was used to detect significant change in teacher rating of the behavior problem level of students over the course of the year. The BSP teachers indicated that, overall, students showed improvement in total problem scores and internalized scores, and no improvement in externalized behaviors. Elementary student ratings showed more improvement than secondary students.

Specifically, elementary students' total problem scores decreased by 4 points and externalized behavior scores decreased by 3 points. Internalized problem behaviors showed a significant drop of 5 points. Home school teacher ratings of both elementary and secondary students showed a .25 increase in total problem scores, a 3 point decrease in internalized behavior, and a 2.3 increase in externalized problem scores. Overall, no significant deterioration in behavior scores was evident.

Assessment of behavioral change was also documented by tracking IEP goals. There were 18 goal comparisons possible, and of these 13 comparisons showed improvement and 5 showed significant improvement. Five comparisons showed no improvement or a slight decrease. However, no comparison of IEP goals showed a significant decrease.

Documentation of progress on IEP goals indicated that students made immediate improvement in behavior. Behavior changes plateaued over time, but the plateaus were much better than the baseline levels of performance. Overall, BSP students achieved IEP goals 80% of the time in the program. This compares favorably with students with BD studied by Conoley & Peterson (1989) which found that students with less severe disturbances exhibited on-task behavior 78% of the time.

A final question was whether BSP students made differential progress on various types of behavior goals. The results showed that BSP students were relatively more successful on classroom skills goals and self esteem goals over other types of goals.

Return to Top

Discussion

It is evident that students referred to BSP exhibit a significantly more severe level of problem behaviors and individual and family psychosocial stressors than the general population with BD. Students of BSP experienced high levels of psychosocial stressors that were associated with significant maladjustment. These results provide a quantified measure that BSP students exhibit a level of behavioral and emotional dysfunction to warrant the level of intervention provided by the program.

It is of particular interest that students at BSP did exhibit significant improvement in academic achievement. This is a remarkable finding in the context of previous research indicating that, in general, day treatment programs do not do a good job in supporting such gains. This result may confirm the view that children with BD respond best to treatment environments that provide opportunity for academic success, that reward prosocial behavior, that provide positive relationships with adults who model and train prosocial behavior and values, and that focus on student strengths and adjustment to the educational environment (Goldstein, Harootunian & Conoley, 1994; Knitzer, Steinberg, & Fleisch, 1990).

Performance on IEP behavior goals proved to be a more responsive indicator of behavior improvement than the CBCL-TRF. As a result, changes of teacher ratings of problem behaviors were small or not significant in most cases. It should be noted that the comparison of problem behavior ratings did not indicate any significant deterioration. Given the severity of problems and psychosocial stressors the participant population experience, the lack of deterioration of problem behavior ratings may be seen as an indicator of positive progress.

BSP is an environment which focuses on development of trusting adult/student relationships, that maintains safety, that can provide extensive amounts of time to resolve behavior problems, and where there is a persistent pursuit to find a way to teach each child. The improvement in IEP goals in the category of classroom skills and self esteem suggest that BSP is an environment that can manage aggressive behavior and at the same time give these children an opportunity to succeed and learn to self manage their behavior. Elementary students made the largest gains in both academic and behavioral measures, indicating early intervention is an important treatment consideration.

The implications for future study are that results and continued data collection can be used to determine what program components are most effective and to assure that the program continues to maintain its success in developing academic and behavioral skills for children with severe levels of BD.

Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

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Designing, Implementing, and Evaluating a School-Based Psychoeducational Group for Children with Behavioral Problems from Families with Substance Abuse Issues

Authors

Introduction Method Results References
Return to Table of Contents

Introduction

Research indicates that children from families with substance abuse issues suffer increased rates of social and emotional problems. Sometimes, though not always, these problems emerge in the form of behavioral acting out in school. School personnel are often unaware of the child's family circumstances and the child is labeled as "the problem." Even in those cases where familial substance abuse is known or suspected, resources to adequately address the child's needs are lacking. As such, children from families with substance abuse issues may advance through school acquiring increasingly poor academic and behavior records without needed intervention.

Some children from families with substance abuse issues, particularly girls, internalize their fears, frustration, loneliness, and anger, adopting a more isolated, withdrawn presentation. These children are rarely noticed by school personnel at all and their psychosocial problems are likely to be entirely unaddressed.

Substance abuse is a major contemporary social problem, particularly in America's inner cities, where treatment resources are few. Consequently, children living in low-income, inner-city communities are at particular risk for the psychosocial problems attendant upon familial substance abuse. There is an urgent need for services for these children; public schools provide an opportune location for such intervention.

This paper describes the development and testing of a structured school-based psychoeducational group intervention designed to address common psychosocial difficulties presented in school settings by children who experience familial substance abuse. This two-year project was funded by a grant from the New York Community Trust to the first author. Data presented are based on first year findings.

Return to Top

Method/Procedures

Sites/Subjects

Three inner-city Philadelphia elementary schools, selected for their locations in communities known for high rates of drug trafficking and drug-related crime, participated in this project. During the project's first year, eight treatment groups were conducted in two of these schools, one located in a predominately African-American low income community in West Philadelphia, and the other in a racially and ethnically diverse neighborhood of poor and working class families.

In each participating school, project staff presented an informational session on substance abuse to all third through fifth grade classes. Parents were notified that substance abuse education would be taking place in their child's school including small group discussions; they were requested to contact the school principal if they did not wish their child to participate. At the end of each classroom presentation, children who wished to discuss additional worries or concerns about substance abuse in their families or neighborhoods were invited to sign up to participate in a series of small groups to be held in the school. The names of children indicating a desire to participate were reviewed by school guidance personnel and those with classroom behavior problems and/or whose families were known or suspected of being substance-involved were targeted. One hundred eight subjects were selected in the two schools.

The 50+ study subjects in each school were randomly assigned to two groups; half received the intervention in the Fall semester and the other half in the Spring, thereby forming a naturally occurring control group for subjects participating in the Fall groups.

Intervention/Program

The intervention was designed to follow the format of a widely used, highly structured curriculum for groups of children of parents with alcoholism entitled, "Children Are People, Too." This curriculum uses an 8 to 10 session treatment model, each session following a similar format with repeated opening and closing exercises.
A specific issue relevant to the psychosocial concerns of children who have family issues of alcoholism is addressed in each session. Topics included: identifying and appropriately managing feelings about parental addiction, personal safety issues, understanding substance abuse, how to interact with peers, and others.

Because the "Children Are People, Too" curriculum was designed to be used in conjunction with addictions treatment for a parent with alcoholism and presupposes the support and involvement of a second, parent who does not drink, many aspects had to be revised for a population where children often live with a single parent who is frequently unable to address his/her addiction. Another significant difference was that most children in our sample were concerned with the effects of crack-cocaine and other illicit drugs on family members, rather than alcohol dependence, although many times these co-occurred. Drug-related violence both within the family and in the neighborhood was also a primary concern of our subjects and is unaddressed in the "Children Are People, Too" curriculum.

Finally, the "Children Are People, Too" curriculum relies heavily on the verbal ability of participants. Our subjects tended to have limited verbal skills and, thus, were highly dependent on other forms of self-expression such as drawing, singing, and story-telling. Also, because many of the children had learning disabilities, attention deficits, and problems with impulse control, we found it necessary to make significant adaptations to the curriculum to accommodate the special needs of these children.

Groups were held once a week during school hours for 10 consecutive weeks during the fall and spring semesters. Each group session lasted one hour and followed a highly structured format. Pre- and post-testing were done at the first and last group sessions.

Measurement/Instruments

All subjects were tested at three points in time: in early Fall before any groups were held, in late Fall after the first round of groups, and in late Spring after the second round of groups took place. Data were gathered on both experimental (Fall group participants) and control subjects (Spring participants) in this way.

Three standardized self-report instruments were used. Each instrument was selected to reflect an issue found in previous research or in clinical observation to be of particular concern to children from families with substance abuse issues. Instruments used included: the Nowicki-Strickland Locus of Control Questionnaire (Nowicki & Strickland, 1973); the Children's Loneliness Questionnaire (CLQ; Asher & Wheeler, 1985); the Self-Perception Profile for Children (Harter, 1985). Data on subjects' classroom performance and behavior were collected from teachers using the Teacher's Report Form (TRF) of the Child Behavior Checklist (Achenbach & Edelbrock, 1986). Group leaders also rated participants with regard to their perceived levels of comprehension of the key concepts contained in the curriculum.
Return to Top

Results and Implications

Findings from the first year of this project, though limited because of the small sample size (48 experimental subjects and 48 controls completed treatment and data collection) suggest that a structured psychoeducational group intervention of relatively brief duration aimed at children from families with substance abuse issues can help to decrease inappropriate classroom behavior and other social difficulties. Teachers' reports on the TRF indicated significant changes in several areas of classroom behavior, including peer relations, interpersonal aggression, and disruptive conduct.
Group leaders' ratings of participants' comprehension of group concepts illustrate the importance of adapting a standard curriculum to the needs of the population treated. Slightly over half of the children (N= 56) who participated in the intervention during the first year understood half or fewer of the concepts presented. Just forty-five percent (N= 47) understood most or all concepts presented.

We hypothesized that a child's level of comprehension of concepts would affect the degree of change that took place on the independent variables measured including self-concept, loneliness, locus of control, and classroom behavior. However, analysis of variance found no significant association between level of comprehension and the degree of change reported on these dependent variables.

Finally, findings from the self-report instruments were mixed. The Children's Loneliness Questionnaire found higher than average levels of loneliness among the subjects in this study&shyp;a finding consistent with the clinical literature on the effects of parental substance use on children. On the other hand, locus of control scores for study participants were close to published norms for same-age children, an unexpected finding given the literature which suggests that children from substance-involved homes are more likely to demonstrate externalized locus of control. Similarly, mean scores on the subscales of the Self-Perception Profile for Children were very close to normative means published by the instrument's author (Harter, 1985).

T-tests were carried out on each of the dependent variables to determine if there were significant changes on any of the dimensions assessed. Only the Children's Loneliness Questionnaire showed significant pre- and post-test differences, with significantly lower scores post-treatment for the treated group

(N = 43; T = 2.3421; p = .02). This finding suggests that children who participated in the intervention achieved one of the project goals: to decrease social isolation and connect with other children with similar experiences with familial substance abuse.
Additional data are currently being collected during the second project year which will allow for more data for analysis and greater confidence in study findings.

Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

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A Controlled Study of Foster Children with Emotional/Behavioral Disturbances: Equivalence of Groups Across Characteristics

Authors

Introduction Method Results Discussion References
Return to Table of Contents

Introduction

Many children with emotional/behavioral disturbances are adjudicated dependent, remain in the foster care system for years, experience frequent transfers from one placement to another, and make little or no progress toward reunification or adoption, or toward improved emotional/behavioral adjustment. The Fostering Individualized Assistance Program (FIAP) was developed to provide individualized wraparound supports and services to foster children with emotional/behavioral disturbances and to their families (i.e., foster, biological, and/or adoptive). The outcomes hoped for were a decrease in the rate of placement changes, improvement in emotional/behavioral adjustment, and an increase in the likelihood of family reunification or other permanency arrangements.

The FIAP intervention was evaluated in a controlled, random-assignment study, which compared a sample of at-risk children receiving the individualized, wraparound process (FIAP group, n = 54) with a comparable sample of children experiencing practices that are standard in the foster care system (SP group, n = 78). The initial demographic variables, scores on certain normed instruments, and history of family and child risk factors, are presented in this article to evaluate equivalence of the two randomly established groups (FIAP and SP) to each other, and to the populations of children with emotional/behavioral disturbances found in other major studies.

Return to Top

Methods

Subjects and Settings

The target population was children in foster homes or group shelter care at the start of the study who had, or were at risk of having, emotional/behavioral disturbances (EBD). Foster care caseworkers completed screening checklists of risk factors identified in previous research (Boyd, Struchen, & Panacek-Howell, 1989) for children in their caseloads between the ages of 7-15, without mental retardation. The "at risk" pool was identified as those children having at least three major risk factors, and 132 children were randomly assigned from this at risk pool to either the FIAP or the SP group.

Return to Top

Data Sources and Analyses

All children and their caregivers in both groups were interviewed in their homes every six months by trained interviewers blind to the group assignments. Both normed instruments such as the Child Behavior Checklist (Achenbach & Edelbrock, 1983) and structured interviews were used. Additional data was obtained from computerized records of foster care placement and delinquency histories, case records, and school records. Differences between groups were tested by Chi-square analysis, and one- or two-way ANOVAs, as appropriate to the data.

Return to Top

Results

Severity and Equivalence of FIAP and SP Groups

There were no significant differences between FIAP and SP groups in the proportion of males vs. females, Whites vs. non-Whites, or in the number of children in each of three age groups (See Table 1). Also, there were no significant differences in the average age of children in FIAP vs. SP groups (11.8 vs. 11.6 yrs.), time in foster care prior to entry into the study (31.6 vs. 30.7 months), or number of placement changes in foster care, per child per year, prior to the study (3.7 vs. 4.2). However, youth ages 13-15 had significantly higher residential placement change rates (6.02 and 6.50) than the other two age groupings (f = 18.8, df = 2,126, p = .000).

All scores on both the CBCL and YSR (Youth Self Report) were reported as T scores, with a mean of 50 and standard deviation of 10, in order to combine results from both genders and all age groups. The FIAP and SP groups were not significantly different at entry into the study in total behavior problem T scores on either CBCL or YSR. This similarity between FIAP and SP groups also held for the externalizing syndromes on both instruments. The only significant difference between groups was for the internalizing syndrome on the CBCL, for which the SP group had lower T scores on the internalizing syndrome than the FIAP group (SP = 60.0, FIAP = 64.5; p = .02).

Comparison with Other Populations of Youth with EBD

A comparison of the FIAP study sample to the samples in each of two important national studies was made. The first study used was the 812 children in the National Adolescent and Child Treatment Study (NACTS; Silver, Duchnowski, Kutash, Friedman, Eisen, Prange, Brandenburg, & Greenbaum, 1992). Youth in the NACTS sample had all been identified by the school systems as severely emotionally disturbed (SED), and were receiving special educational services for SED, or were receiving publicly funded residential mental health services.

A second comparison was made with a sub-sample of 87 youth from the Alternatives to Residential Treatment Study (ARTS; Duchnowski, Johnson, Hall, Kutash, & Friedman, 1993). Like NACTS, the youth in ARTS were all enrolled in programs considered to be "deep end" placements (primarily residential programs), and were all identified as having emotional disabilities. The youth in the FIAP study, compared to either the NACTS or ARTS samples, were in less restrictive placement settings, with none currently in mental health treatment settings and only 57% receiving ED/BD school services at entry to this study.

As shown in Table 2, there were some demographic differences between the FIAP study sample and the NACTS and ACTS samples. By comparison, the FIAP study sample was younger (mean = 11.7, range = 7-15 yrs), compared to the sample in NACTS (mean = 13.9, range = 8-18 yrs) and ARTS (mean = 14.2, range = 7-18 yrs). Also, compared to either the NACTS or ARTS samples, the FIAP study sample was less dominated by males (FIAP = 60%, NACTS = 75%, and 64% for ARTS), and had a larger proportion of ethnic minorities (FIAP = 39% minorities, compared with just 29% for both ARTS and NACTS).

The FIAP sample had a mean total problem T score on the YSR of 61.1, almost exactly the same as that reported for the ARTS sample (62.2). On the CBCL, the total problem score mean was 67.4 for the FIAP sample, compared to 71.5 for ARTS, a difference of less than 0.5 SD. The CBCL externalizing syndrome scores for the FIAP study sample (mean = 68.2) were slightly, but not significantly, lower than those of school-based (mean = 69.8) vs. residential (mean = 72.9) NACTS children. CBCL internalizing syndrome scores for the FIAP study (mean = 61.8) were lower than that reported for both school-based and residential children in NACTS (mean = 66.6, and mean = 71.6 respectively).

Using the same total problem score cutoffs used by ARTS to classify their sample into probably "normal" (T < 60) or "deviant" (see Achenbach, 1991 for discussion of comparison populations), caregivers rated 81% of the FIAP sample's behavior as deviant (compared to 98% for ARTS), and 59%

of the youth rated their own behaviors as deviant (compared to 66% of the ARTS youth).
Family History Risk Factors for FIAP Children.

At entry to the FIAP study, the average time in foster care for FIAP study children exceeded the 18 months legally mandated by the State of Florida by over a year (FIAP = 31.6 months, SP = 30.7 months), ranging from 3 months to 7.5 years. While in foster care, the average child experienced 4 residential placement changes per year (excluding brief runaway episodes; FIAP = 3.7, SP = 4.2). There was a significant difference between the two study counties, (5.2 vs. 3.3 changes/year) with the higher rate occurring in the more urban county (f = 7.7, df = 1,130, $p < .01$), but there were no significant differences between the FIAP and SP groups.

More of the FIAP study sample had experienced out-of-home placements specifically due to abuse and/or neglect reports in the period prior to the study, 72% of a subsample of 87 from one urban county, compared to 56% of the ARTS sample. Over 50% of that sub sample (n = 63) had records of 4 or more abuse investigations each (range = 2-14). Child protection investigations found that for only 17% of the youth were no specific indications confirming the abuse or neglect&shyp;no investigations were closed as having no indications.

Many of the FIAP study children reported family and environmental factors that could suggest higher risk for emotional/ behavioral disturbances (See Table 3). On the initial interview, 43% of the children reported one or more members of their family had serious substance abuse prob-lems, 54% reported a family member had been incarcerated, 21% reported a family member had a history of suicide attempts or psychiatric hospitalization, and 44% reported a parent with serious emotional disturbance (no differences between FIAP and SP groups were statistically significant across those variables; $p > .05$).
Return to Top

Conclusions and Interpretation

It is apparent from the data presented and from other indicators such as high levels of involvement with the juvenile justice system (Lee, Clark, & Boyd, 1993), and use of psychotropic medications, that the children in the FIAP study showed high levels of EBD, close to that of other identified EBD populations (NACTS and ARTS). Although there was one significant difference on sub-scale scores of the CBCL and YSR between FIAP and SP groups, the preponderance of evidence on adjustment scores and other indicators shows close equivalence of the FIAP and SP groups to each other. Thus, it seems reasonable to conclude that the randomization to control and experimental groups was successful, as was the selection process for identifying a population of EBD children from a general foster care population.
Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

Table 1

Return to Artcle

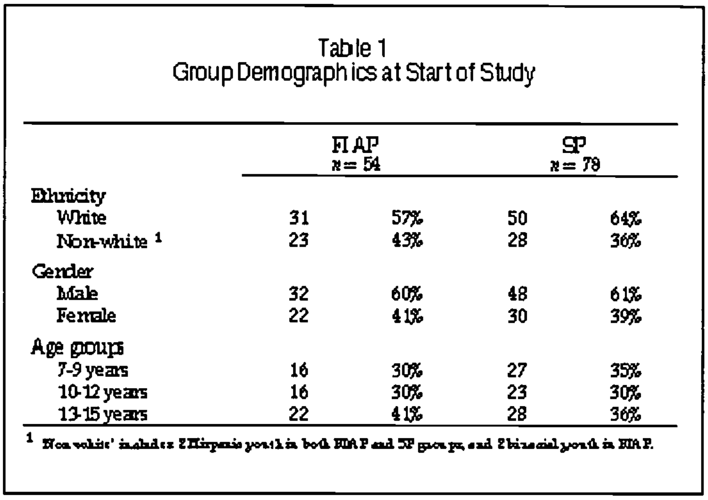

Table 1
Group Demographics at Start of Study

	FIAP n = 54		SP n = 78	
Ethnicity				
White	31	57%	50	64%
Non-white [1]	23	43%	28	36%
Gender				
Male	32	60%	48	61%
Female	22	41%	30	39%
Age groups				
7-9 years	16	30%	27	35%
10-12 years	16	30%	23	30%
13-15 years	22	41%	28	36%

[1] 'Non-white' includes 2 Hispanic youth in both FIAP and SP groups, and 2 biracial youth in FIAP.

Table 2

Return to Article

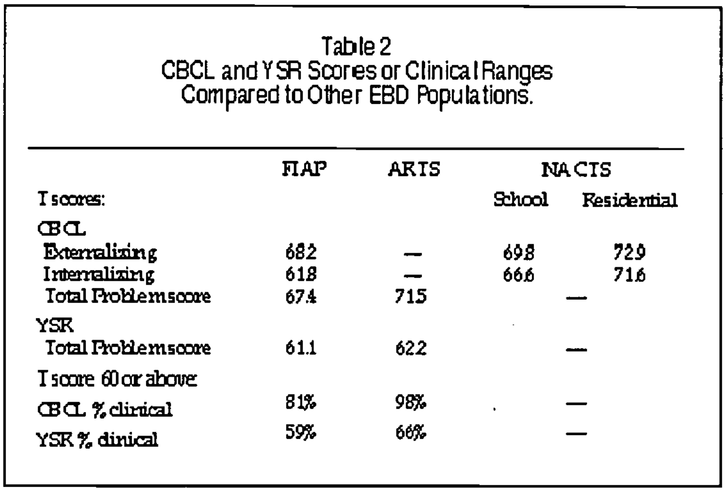

Table 2
CBCL and YSR Scores or Clinical Ranges
Compared to Other EBD Populations.

	FIAP	ARTS	NACTS	
T scores:			School	Residential
CBCL				
Externalizing	682	—	698	729
Internalizing	618	—	666	716
Total Problem score	67.4	715	—	
YSR				
Total Problem score	61.1	622	—	
T score 60 or above				
CBCL % clinical	81%	98%	—	
YSR % clinical	59%	66%	—	

[Home] [Search] [Index]

Table 3

Return to Article

Table 3
Family Risk Factors and Child History for FIAP and SP Groups

	FIAP		SP	
Family risk factors	n = 54		n = 78	
Incarceration	27	50%	44	56%
History of emotional disturbance	24	44%	34	44%
Substance abuse	22	41%	35	45%
Psychiatric hosp./suicidal	14	21%	14	21%
Child history factors				
Time out of home	31.6 mos		30.7 mos	
Placement changes/year	3.7		4.2	
Urban county	5.1		5.3	
Rural county	2.8		3.6	
Abuse/neglect investigations (n=87, urban only)	72%		73%	
Mean investigations/child	4.5		3.9	
Special education	49%		62%	

[Home] [Search] [Index]

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Florida Mental Health Institute, University of South Florida,1996

Impact of an Experimental Foster Care Intervention on Emotional and Behavioral Adjustment: Examination of Preliminary Outcomes Using Growth Curve Analysis

Authors

Introduction Method Results Discussion References
Return to Table of Contents

Overview

Over the past several decades, foster care has been expected to be a major solution to the plight of children who were neglected, abused, or abandoned by their families of origin. However, despite many attempts toward meeting the mandates (e.g., permanency, preventing out-of-home placements) of the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272), it has been widely asserted that the foster care system is a part of the problem besetting these children (e.g., Bryant, 1993).

Despite evidence from providers and administrators of foster care services that over ninety percent of all children in out-of-home care ultimately return home ("Keeping families together," 1993), models of family-focused-permanency planning that include family preservation, reunification, and a family-focused therapy orientation have not been consistently incorporated into services for children residing in out-of-home placements. When family-focused programs of family preservation have been tried, improved child placement rates have been obtained. In a review of samples comprised primarily of child welfare cases, placement outcomes were improved with programs that emphasized therapeutic interventions with the family versus program models that emphasized community, and concrete services or crisis intervention (Nelson, Landsman, & Deutelbaum, 1990).

There has also been a call for the children's service system to adopt alternative values and therapeutic interventions with children and families in order to provide for the protection, nurturance, and development of children and to ensure the integrity of their families (e.g., Boyd, 1992). The Fostering Individualized Assistance Program (FIAP) study was designed to implement, and to investigate the effects of, an individualized, case-managed, family-focused collaborative intervention with children and their families&shyp;natural, relative, foster, or adoptive&shyp;in the child welfare system (Clark & Boyd, 1990, 1992). This summary provides preliminary outcome data for a controlled experiment, with random assignment, with a group of children in foster care who received FIAP services and a comparable group who were supported by practices standard to the foster care system. More specifically, findings from analyses of children's wave 1 (time of entry into the study) through wave 7 (3 years after entry) Youth Self-Report (YSR; Achenbach, 1991) data using growth curve analysis (Bryk & Raudenbush, 1992) are reported and the implications of these findings are discussed.

Return to Top

Method

Subjects

Children in the state foster care system were eligible for inclusion in this study if they were (a) in temporary custody of the state, due to having been abused or neglected; (b) 7 years to 15 years old; (c) living in a regular foster home or in an emergency foster shelter facility; and (d) having behavioral and emotional disturbances, or at risk of such, as defined by several behavioral screening indicators (e.g., potential harm to self or others, use of drugs and/or alcohol, engagement in abnormal sexual behavior). Children from this pool were selected using a computer-generated random-number system and assigned to the FIAP enhanced services group or the standard practice (SP) control group. To compensate for a predicted higher attrition rate within the SP group (e.g., due to extended runaways or voluntary dropouts), approximately 50% more subjects were randomly assigned to the SP group than to the FIAP group. A total of 132 foster children participated, 54 assigned to FIAP and 78 assigned to SP.

Intervention Conditions

Standard Practice Group (control group). The standard practice control group received the prevailing care, support, and services that the state system provides to children who have been adjudicated as dependent and placed in the foster care system.

FIAP Group (experimental group). The FIAP group received services aimed at improving behavioral/emotional adjustment and placement stability, in addition to services received by the standard practice group. These additional services consisted of four major components: strength-based assessment, life-domain planning, clinical case management, and follow-along supports and services (Clark, Prange, Lee, Boyd, McDonald, & Stewart, 1994; McDonald, Boyd, Clark, & Stewart, 1994) .

Data Collection and Instrumentation

Data on behavior problems were collected through interviews, conducted at six month intervals for three years (seven waves of data including the first data collection). The data analyzed for this summary were provided by the youths themselves who completed the Youth Self-Report (YSR; Achenbach, 1991). Specifically, we analyzed the YSR Total Problems Scale which was composed of eight problem subscales:
(1) withdrawn, (2) somatic complaints,
(3) anxious/depressed, (4) social problems,
(5) thought problems, (6) attention problems,
(7) delinquent behavior, and (8) aggressive behavior.

Analysis

The specific analyses performed consisted of a sequential progression of analyses using two through seven waves of YSR data with treatment condition, age, and gender as second-stage or between-subject factors. The first analysis utilized two waves of data, comparing subjects change between waves 1 and 2. For each subsequent analysis, one wave of data was added (e.g., the second analysis, utilizing three waves of data, compared subjects change for waves 1 through 3). This sequence was followed until the final analysis, which utilized all of the current data collected on subjects. Growth curve analysis was used for all analyses except for the analysis of change between waves 1 and 2 which was done using a repeated measures ANOVA. The necessary minimum of three waves of data precluded the use of growth curve analysis in this instance.

Growth curve analysis, known as hierarchical linear modeling, random regression modeling, random effects modeling, "multi-level" modeling, and empirical Bayes modeling, was the primary statistical method chosen for analyzing data. The growth curve approach offers several major advantages compared to more traditional means for analyzing longitudinal data such as repeated measures ANOVA. Specifically, (a) growth curve analysis places explicit focus on how individuals change in addition to how groups change, (b) growth curve analysis is flexible with regard to the treatment of missing data; it is not necessary for subjects to have data across all waves of collection in order to be included in the analysis, and (c) the assumptions underlying the growth curve approach are more realistic than those underlying more traditional approaches (Bryk & Raudenbush, 1992; Gibbons et al., 1993; Hedecker, 1993).

Growth Curve Analysis. In the growth curve framework, change is represented in a two-stage model encompassing both within- and between-subject factors (Bryk & Raudenbush, 1992). In the first stage, each person's observed scores are modeled as a function of an individual growth function (i.e., within subjects) plus random error. When these growth functions, which may be linear or non-linear, are applied to each individual's observed scores, they produce trend patterns for each individual subject (each subject's personal change pattern). These individual trend patterns are outcomes to be explained in the second stage of analysis. In the second stage, the parameter estimates (e.g., the slopes) describing the individual trend lines, are tested for variation as a function of group differences (i.e., between subject factors such as treatment condition, gender, and age).

Return to Top

Results

Results of the analyses showed that scores from both groups of subjects decreased significantly over time indicating improvement in emotional/behavioral adjustment (e.g., for the wave 1 through wave 7 analysis, t = -6.41, p = .000). In addition, a significant treatment effect (F = 3.95, p = .049) in favor of FIAP was shown for the period between waves 1 (entry into study) and 2 (6 months later). This main effect of treatment, however, was not present in results of the analyses from later waves. Instead, results of all analyses from waves 1 through 3 up to waves 1 through 6 indicated that a marginally significant interaction for the effect of status by age by gender on individual change patterns was present. This interaction was found to be significant in the wave 1 through 7 growth curve analysis discussed in detail below.

Wave 1 Through Wave 7 Growth Curve Analysis

In the growth curve analysis for waves 1 through 7, we included an intercept parameter (i.e., where children start out) and a linear slope parameter (i.e., children's linear change over time) to model children's individual-level YSR change patterns. Additionally, it was made apparent through a series of preliminary tests and procedures, including the plotting of individual's YSR scores over time, that while many children exhibited linear patterns of change, many others exhibited curvilinear patterns of change. Therefore, a quadratic parameter was also used to model individual-level YSR change patterns. A sample of the plots used to determine the parameters employed in the level-1 model is presented in Figure 1. Subject A in Figure 1 shows a linear change pattern while Subject B's change pattern is curvilinear, indicating the need for both linear and quadratic parameters.

Results of the first stage of this analysis (i.e., specifying the model of individual change patterns) indicated that significant variation existed in individual change patterns. Results of the second stage of this analysis (i.e., examination of individual change patterns in relation to group-level variables) showed a significant interaction for the effect of status by age by gender on these individual change patterns (t =-2.24, p =.025).

This interaction indicates that efficacy of the FIAP intervention depends on the subjects' age and gender. For older FIAP males and younger FIAP females, there was a significantly greater decline in YSR scores compared to their SP counterparts.

Return to Top

Conclusion

Results of the analyses showed that the FIAP intervention accelerated positive change in emotional/behavioral adjustment for children between waves 1 and 2, and this greater rate of positive change endured for older FIAP males and younger FIAP females, relative to their SP counterparts.

From a systems perspective, older adolescents were more likely to have children&shyp;and while females are usually encouraged to remain in the foster care system for the benefit of their child&shyp;their male counterparts may be more likely to be promoted to live independently. Because the FIAP intervention was specifically designed to provide support and encouragement for the transition from foster care assistance to independent living, (or to obtain stable placements within the foster care system), it makes some clinical sense that older FIAP males would show greater improvement compared to their standard practice counterparts who may not get this support. The significant impact for younger FIAP versus standard practice females appears to have no direct ties to the specific type of supports given by the FIAP intervention. Possibly this reflects the over-representation of female family specialists who bonded more readily with same sex younger FIAP youth.

These small effects regarding clinical adjustment outcomes may be understandable in light of the complexities involved in use of a non-intensive therapeutic intervention to improve clinical adjustment with extremely challenging children and their families (e.g., Bickman, 1993; Cross, Fallon, Gardner, Adnopoz, & Saxe, 1992). As wraparound systems of care strategies are refined and ameliorated, as family systems therapy is incorporated more adequately (Henggeler, Melton, Smith, & Schoenwald, 1993), and as personnel selection, clinical training, and field supervision methods are strengthened, the fidelity of the individualized wraparound approach should be improved.

In addition to these results, it should be noted that the impact of FIAP on placement-related outcomes has been substantial (Clark, Lee, & Prange, in press; Clark, Prange, Lee, Boyd, McDonald, & Stewart, 1994). Although tentative at this time, the interim outcome results suggest that: (1) FIAP children are significantly less likely to change placements than are those in the SP group; and (2) FIAP children are significantly more likely than SP children to be in permanency settings with their parents, relatives, adoptive parents, or living on their own. Data also suggest that FIAP children in permanency placements tend to show better emotional/behavioral adjustment than do SP children in permanency placements (Clark, Prange, Lee, Boyd, McDonald & Stewart, 1994). Examinations of community adjustment indicators for subsets of children who have any history of runaways or incarceration, suggest that the FIAP children are showing trends for fewer days in both of these areas (Clark, Lee, & Prange, in press; Clark, Prange, Lee, Boyd, McDonald, & Stewart, 1994). A continuing increase in incarceration days and other deep-end placements by the SP group may ultimately demonstrate the FIAP intervention to be cost effective.

This study also demonstrates some advantages of the growth curve approach for analyzing longitudinal data. The explicit focus on individual, as well as group change patterns, provides a conceptual focus not offered by more traditional statistical methods. The information provided by this approach on inter-individual variation in personal change patterns and differences in the shape of these patterns (e.g., linear versus quadratic), suggests improved conceptualization. Also, a greater number of subjects included and more realistic assumptions in the HLM analyses resulted in increased statistical power relative to more traditional analyses.

Return to Top

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Return to Top

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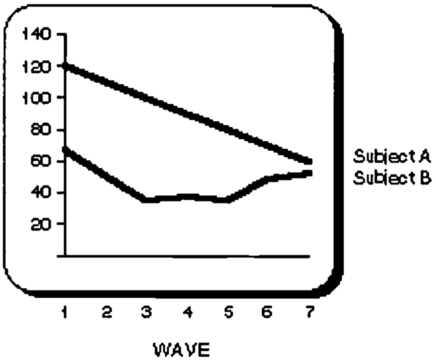
[Home] [Search] [Index]

Figure 1

Return to Article

Figure 1

YSR Total Problem Raw Scores*



* Two sample individuals

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies,
Florida Mental Health Institute, University of South Florida,1996

Examining the Nature of the Independent Variable in a Controlled, Wraparound Foster Care Study: What Worked and Why?

Authors

Introduction Method Results Discussion References
Return to Table of Contents

Introduction

The Fostering Individualized Assistance Program (FIAP) was designed to study the outcomes of provision of highly individualized, wraparound services (the independent variable) versus standard practice for two randomly assigned groups of children with severe emotional disturbance in out-of-home foster care (FIAP group, N = 54; Standard Practice group, N = 78).

For each FIAP child, one of four Family Specialists (FSs) was asked to do whatever was necessary, usually through teams of adults influential in the lives of their clients, to: (1) identify the strengths and needs of each child and the potential permanent placement family; (2) devise and implement a service plan capitalizing on both strengths and needs of each child and family (across 12 life domains); (3) monitor and record progress in each client's notebook; (4) advocate and trouble-shoot, often in innovative, creative and non-standard ways; (5) adapt and modify the plan as dictated by the constantly changing child, family, worker and system circumstances; and 6) follow along and support the client after permanent placement.

Preliminary analysis of the first 30 months of data suggested that the FIAP approach was moderately successful:

- FIAP children were significantly less likely to change placement than those in the Standard Practice (SP) group;
- FIAP children were more likely to show significant initial improvement in emotional/behavioral adjustment, a gain matched by SP children at the 12th month of intervention;
- both groups show significant levels of improvement in emotional/behavioral adjustment over time; and
- FIAP children were significantly more likely to be in permanency settings with their parents, relatives, adoptive parents, or living on their own.
- Additionally, the data suggest that FIAP children in permanency placements tend to show better emotional/behavioral adjustment than do SP children in permanency placements. Finally, community adjustment indicators for subsets of children who have a history of runaways or incarceration show that FIAP children accrue fewer days in these areas (see Lee, et al.; Rose, Prange, Greenbaum & Clark, this volume).

It has always been the intent of the authors to evaluate, not only the effectiveness of the overall FIAP approach, but also what aspects of its individ-ualized methodology (the independent variable) appear to be most and least successful in meeting the needs of children and their permanency families. As the clinical application of FIAP neared its ending date, efforts were made to identify the ten children with whom FIAP had been most successful (Top Group) and the ten with whom FIAP had been least successful (Bottom Group). Success, of course, related to how well each child was doing in relationship to permanency, number of placements, length of stay, school progress, absence of illegal or otherwise handicapping behaviors, and other highly individualized, clinical variables.

Relevant factors for these two subsets of the experimental group are being analyzed in an effort to discern and describe what worked, what did not work, and why. Preliminary findings are relevant to the study's research questions and to the role and nature of independent variables in the field of applied human service research.

Return to Top

Method

Context

FIAP was established as a collaborative effort between the state/district offices of mental health and child welfare and the University of South Florida. FIAP, however, was administratively separate from these offices and was permitted an adjunctive role, without being assigned control over either mental health or child welfare services for its clients. Thus, FIAP FSs provided a type of co-case management, with the regular foster care counselors already assigned to these children, who maintained primary legal and service relationships with the children and families. This proved to be reasonable workable and successful in some cases, and almost impossible in others. Family Specialists attempted to do necessary assessments, create the teams, devise, implement, monitor and track individualized service plans within the prevailing system.

The real world result was the formation of somewhat loosely knit teams, per child, co-case managed by a FIAP FS and the assigned foster counselor. In many cases, the FS role became primary, in light of the overburdening active caseloads of each state foster counselor (e.g., 40-60 clients). Consequently, the first 18 to 24 months of the study were spent in adjunctive clinical and administrative balancing, while developing and practicing individualized programming as consistently as possible.

The philosophy of individualization which FIAP sought to develop and implement implied rigorous practice of specific methods, consistent with its inherent values. Initially, one to one, office-based supervision of each FS by the FIAP clinical supervisor was provided using a mentoring model. This was augmented by consultation and weekly feedback and brainstorming sessions of the FIAP clinical team. However, what did not develop was an effective method of hand-on, field based oversight and supervision which may be necessary to enhance clinical accountability and program fidelity.

The Family Specialist Log

About 18 months into the program, a FIAP Family Specialist (Daily) Log Per Activity, per client, was developed and implemented for ten months&shyp;long enough to derive data to analyze what, how, when, where, how long and with whom FS activities were actually occurring. The log was a matrix for recording FS activities for each 24 hour period, including the following defined activities: Prepare Follow Up; Advocate; Facilitate or Coordinate; Inform or Communicate; Monitor or Supervise; Observe or Assess; Plan or Problem Solve; Counsel or Support; Provide or Broker; Reinforce; and Train. These activities were cross referenced with specific definitions for date, clock time, number of minutes, contact person(s), contact method, place of contact, and life domain(s) involved. An overall 65% inter-observer reliability was obtained across definitions, across Family Specialists.

These data have been only partially analyzed as relates to the mean number of contacts, the total intervention time, and the types and times of contacts. Additional analyses are in process, especially as to relationships among program activities, children, FSs, and outcome measures, and as to variations in practice and effectiveness among the four FSs.

Using data from these logs, client records, and clinical impression, 10 most and least successful FIAP clients were identified from the original 54. Demographic data and log data for these 20 children were analyzed, to begin to discriminate any critical aspects of FIAP's independent variable. Additional

analyses are in process, especially as to variations in practice and effectiveness among the four FSs.
Return to Top

Results

Preliminary analysis indicated that the two groups of ten were homogenous as to ethnicity, gender, length of time spent in foster care, and mean total number of FS/client contacts. The two groups, however, were essentially different from each other in several ways, as shown in Table 1.
Return to Top

Implications

1. Individualized wraparound programs should begin at the earliest possible moment, at the earliest possible age.

2. To the degree possible, staff support and supervision should be field based, perhaps, as opposed to mostly office or group based.

3. Staff turn over is to be avoided, if at all possible. When it occurs, attempts to pair the incumbent with the new staff member should be made, for at least 2-3 weeks. This may enhance essential personal and professional familiarity with each child and family, as well as other key players.

4. The differences in approaches and activities used by different Family Specialists need further analysis, however, this variable is probably the most difficult to measure. If it is assumed that intense, daily supervision of highly accountable, effective individualized wraparound services is required, personality profiles, prior experience, and specialized training for persons willing to work under such circumstances will be needed.

   Initially, FIAP thought that each child's service or treatment team would help ensure reliable, consistent Family Specialist activities once agreement was reached on a service plan&shyp;especially when paired with weekly FIAP team meetings and periodic one-to-one supervisory meetings. The variability of outcomes for children across FSs suggests that something more may be necessary to monitor and promote program fidelity, consistency and accountability. Unpredictable and essentially unmeasureable child, family, worker, system and program variables may require constant on-site monitoring and feedback&shyp;a very expensive and proposition&shyp;especially with professionals who believe they work best alone.

5. The effectiveness of case managers can be maximized by matching case loads to the severity of the families' problems. Many "discharged" clients required rather constant checking and fine tuning&shyp;unfortunately, some families may never reach the independence to become their own successful case managers. FIAP found that 12 cases were often too many to handle effectively, and children who were "permanently placed" often required periodic, intensive follow along monitoring and supports.

Return to Top

Discussion

The authors are encouraged by the positive results of the FIAP study, to date, including significantly better placement and permanency outcomes for FIAP children (Clark, Lee, & Prange, in press). We are confident that the recommended intervention practices that were developed will assist other professionals to more effectively establish individualized services for children and families lost in the foster care system (McDonald, Boyd, & Clark, in press).

The difficulties of accountable, consistent, reliable, faithful application of the programmatic philosophy, values, and enabling methods of highly individualized, wraparound services to foster children with severe emotional disturbance are varied and many. FIAP has learned that efforts to maintain, record, and reliably measure all aspects and activities of the application of its independent variable in the field are complicated and often confounded by the nature of individualized programming, itself. Yet, assuring the implementation of the essential elements of experimental independent (treatment) variables is critical to the validity of measures of experimental dependent (outcome) variables, regardless of research design.

Though FIAP has been highly successful with certain of its clients, mean data analysis of the entire FIAP group may not discriminate either these successes, nor those specific factors within the independent variable most contributory to either success or failure. FIAP shall continue to try to ferret out those factors, through continued analyses of sub-group independent and dependent variables, in both experimental groups (e.g., FIAP and standard practice), but it remains unclear what to recommend to the field, as to how best to accomplish this in field-based research.

The field of applied research in human services may need to recognize that far more (and sometimes far less) goes on in the real world of day to day treatment than projected, planned, or claimed by researchers, at times badly skewing results. Surely, this is even more true in highly individualized methodologies. Analysis of variance, and many other mean-based statistical analyses, do not allow for these inconsistencies, inadvertently resulting in Type I and Type II errors.

It may be implausible to base scientific conclusions as to the efficacy of human service interventions and treatment paradigms on anything less than necessary and sufficient, accountable, reliable, accurate measures of treatment application, aggregated client by client. This being extremely difficult and unlikely, perhaps some sort of combination analyses of case study data, sub-group data (e.g., top/bottom groups), and total group mean data&shyp;involving reasonably reliable, multi-measured estimates of both types of variables&shyp;would be more effective. Perhaps FIAP can let you know.
Keep tuned.

Return to Top

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Return to Top

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The Fostering Individual Assistance Program (FIAP) Study, a collaborative research and demonstration project between the Florida Mental Health Institute of the University of South Florida and the Florida Health and Rehabilitative Services Department was funded, in large part, by the Child and Family Support Branch of the National Institute of Mental Health (Grant No. 1-R18-MH47910) and the Child, Adolescent, and Family Branch of the Center for Mental Health Services (Grant No. 9 HD5 SM51328-04).

Return to Top

[Home] [Search] [Index]

Table1

Return to Article

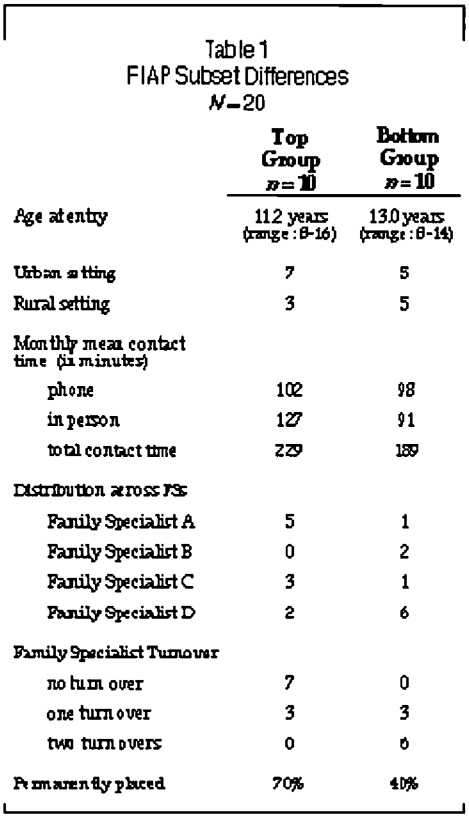

Table 1
FIAP Subset Differences
N = 20

	Top Group *n* = 10	Bottom Group *n* = 10
Age at entry	11.2 years (range: 8-16)	13.0 years (range: 8-14)
Urban setting	7	5
Rural setting	3	5
Monthly mean contact time (in minutes)		
phone	102	98
in person	127	91
total contact time	229	189
Distribution across FSs		
Family Specialist A	5	1
Family Specialist B	0	2
Family Specialist C	3	1
Family Specialist D	2	6
Family Specialist Turnover		
no turn over	7	0
one turn over	3	3
two turn overs	0	6
Permanently placed	70%	40%

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies,
Florida Mental Health Institute, University of South Florida, 1996

The Characteristics of Urban Children and Families Served by Child Welfare Agencies: The Satellite Family Outreach Program

Authors

Introduction Method Results Discussion References
Return to Table of Contents

Introduction

In recent years, child welfare agencies have been challenged with a drastic increase in referrals. For example, in 1992, 1.3 million reports were made on 2.7 million children nationally (Wells, 1994). These reports were made for a number of reasons, including neglect (45%), physical abuse (27%), sexual abuse (17%), and emotional abuse (7%) (McCurdy & Daro, 1994). In addition to the abuse and neglect, the children served by child welfare agencies often experience difficulties in school, struggle with substance abuse problems, and exhibit antisocial behaviors (Trupin, Tarico, Low, Jemelka, & McClellan, 1993). As reflected by the National Commission Report on Child Welfare and Family Intervention (1990), the social service agencies designed to help these multi-need children and youth often cannot provide adequate services to them. As a result, these children and youth may lose their ability to cope with a complex society, fail to successfully transition into adulthood, and drift into institutions and prisons.

Kaleidoscope, Inc., Chicago, Illinois is an agency whose priority is to provide services to those children and youth that have not been effectively served by other social service agencies. These children have been diagnosed as seriously disabled, disturbed, or incorrigible and are in need of intensive treatment service efforts toward integrating them into their home communities and/or family life. The services Kaleidoscope provides are based on the philosophy of Wraparound Care which underscores the importance of unconditional care, intensive case management, individual planning, family involvement, flexible funding, and cultural competence.

Kaleidoscope's Satellite Family Outreach Program uses these principles in serving their children and families that have experienced numerous difficulties and separations. In the present study, an extensive archival review was conducted on the files of all children and families served by Satellite during the years 1990 through 1993. The purpose of this study was to address the question, Who are the children and families served by the Satellite Family Outreach Program and what services did they receive prior to Satellite?

Return to Top

Method

Setting

This study was conducted at Kaleidoscope, Inc., a not-for-profit child welfare agency in Chicago, Illinois. In January 1994, Kaleidoscope received a grant from the Annie E. Casey Foundation to evaluate its Satellite Family Outreach Program. This study is one component of that overall evaluation. The Satellite program serves approximately 25 families at any one time and employs a staff of four administrators, three supervisors, four social workers, and 20 family workers.

Participants

The families participating in this study were parents and children who had received services from Satellite during the years 1990 through 1993. Files were reviewed for 101 families that consented to participate. Information was collected on 133 parents/grandparents and 269 children. The parents and grandparents ranged in age from 19 years to 74 years old (M = 33.8 years). The racial composition of the adults was 71% African-American, 17% Caucasian, 8% Latino, and 4% Other. The majority of the parents were women (78%). The children ranged in age from 3 months to 20 years old (M = 8.93). The racial composition of the children consisted of 73% African-Americans, 12% Caucasians, 10% Latinos, and 5% Other. A slight majority of children were male (51%).

Instrument

The Demographic Overview Form1, Child Version (44 items) and Adult/Family Version (42 items) were designed to identify specific characteristics of Satellite clients. Specifically, the forms focused on background data, reason for referral to Satellite, presenting problems, and previous service utilization.

Procedure

Data collectors were oriented to file format and data collection methods in three steps. First, each data collector met with the first author to review and complete Demographic Overview Forms for a file. This was repeated until the data collector was knowledgeable about the file format and data collection procedures. Second, the data collector and the first author reviewed and completed forms independently. The completed forms were compared and any discrepancies were discussed. If the discrepancies were minimal, the data collector began to review files independently. Additionally, the first author reviewed 20% of the files to assess reliability. Reliability ranged between 89% to 95% across the items with the average reliability being 93%.

Return to Top

Results

Parents

English was the primary language of 92% (N = 122) of this group. Many of the parents were single; 37% (N = 49) were never married, 16.5% (N = 22) were divorced, 5% (N = 7) were widowed, 21% (N = 28) were married, and 11% (N = 15) were separated. Most of the parents lived either alone with their children or with their spouse or significant other. A majority of the parents were not employed (63.2%).

Prior to entering Satellite, the parents had received services from an average of 3.06 different agencies (see Table 3). The most frequently used agencies were the Department of Children and Family Services (96.9%), the Department of Public Aid (65.5%), private agencies (63.3%), and the Department of Mental Health (23.3%). Twenty-three percent (N = 30) of the parents had been admitted to a medical hospital at least once, 14% (N = 18) had been admitted to a psychiatric hospital, and 10% (N = 11) had participated in an in-patient substance abuse treatment program. Many of the parents and their families lived at or below the poverty level (68.4%) and received assistance from the Department of Public Aid (65.5%).

Children

Forty-four percent of the children served by Satellite (N = 119) were in the guardianship of their mothers and 42% (N = 114) were in the guardianship of the Illinois Department of Children & Family Services. The guardianship of the remaining children was 5% (N = 13) both parents, 3% (N = 9) other relatives, 2.6% (N = 7) father, and 2.6% (N = 7) other. The children had been served by an average of 4.12 agencies prior to Satellite. Before entering Satellite, 75% of the children had been residentially placed outside of their natural home on at least 3 different occasions. A great number of the children placed (83%) had been in either relative, general, or private foster care.

Families

When a family was referred to the Satellite program, the referring agency indicated an average of 3.83 reasons for referral. The top four reasons for referral were: the parent lacked the skills or resources to nurture her/his children (69.5%), the referring agency wanted to reunify the family members (47.5%), the parent needed treatment for her/his behavior and emotional difficulties (46.8%), and the family unit had unmet mental health needs (45.3%). The permanency goals involved providing families services so that the children could remain in their home (55%), return to their natural home (42%), remain permanently in the home of a relative (12%), remain with a foster family (6%), or remain in a long-term care facility (1%).

Return to Top

Discussion

The present findings indicate that the children and families served by an urban child welfare agency present many challenges to service providers. Many of the children live in single parent families that are financially supported through public aid. These parents struggle to provide for their children on incomes below the poverty level. A large percentage of families have been involved with state child protective services. Almost half of the children are wards of the state. It is important to note the lack of stability in these families' (especially the children's) lives. Many of the children had lived in multiple residential placements by the time they were 10 years old.

The implications of the present findings are numerous. First, the information may be used to improve Satellite's services through an increased understanding of their clients' characteristics. Second, service utilization histories may provide a basis for Satellite staff to identify unique and creative resources their clients may need but are lacking. Finally, the findings may identify some characteristics of those children and families who seemingly fall through the cracks of existing public systems of care. These are the people who most need comprehensive, community-based services that will help them regain a stable family unit and link them to the resources found in their home areas. With those types of services in place, perhaps these families can become successful and independent.

Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Mental Health Screening in Foster Care: A Model for Community-Based Service Delivery and Research in Baltimore

Authors

Introduction Method Results Discussion References
Return to Table of Contents

Introduction

A major consequence of the poverty, violence, and drugactivity in inner cities, such as in New York, Washington, DC and Baltimore, is the massive influx of children into the foster care system. On any given day, approximately 450,000 children nationwide are in foster care, presenting with more severe and complex problems than were seen a decade ago (Jost, 1991).

The present study extends prior research on the prevalence of mental health problems among foster care children (e.g., McIntyre and Kessler, 1986). Such research is needed to develop effective treatment strategies for these "at-risk" children.
Return to Top

Method/Procedure

Health Clinic personnel administer a combined medical and mental health screening protocol for all abused and neglected children entering out-of-home placement/foster care in Baltimore. A unique public-private partnership, the Health Clinic combines clinical staff from the Baltimore City Department of Social Services (BCDSS); Baltimore Medical System, Inc. (BMSI), a local non-profit community health organization; and Dale and Fogelman Associates, a group of psychologists and other mental health professionals who conduct the mental health screenings. Figure 1 displays the mental health screening model developed by Dale and Fogelman Associates.

The following research findings are based on a random sample of 300 children from the 4073 who received mental health screenings at the Health Clinic in Baltimore between July 1, 1992 and June 30, 1994. It was decided to select 100 subjects from each of three developmental age groups: 2 months to 5 years, 8-12 years and 13-19 years (see Table 1 for a summary of the instruments and criteria used). First, background information &shyp; such as race, sex and reasons for entering foster care &shyp; was tabulated in order to obtain a demographic profile of the population. Second, the cognitive and emotional functioning of these at-risk children was analyzed by developmental age group.
Return to Top

Results: Demographics and Mental Health Functioning

Forty-nine percent of the selected sample were male and fifty-one percent were female. Ninety percent were African-American and nine percent White (see Figure 2 for a demographic summary). Chi-square analysis and analysis of variance were performed in order to determine whether either demographic variable&shyp;gender or race&shyp;had an effect on mental health functioning. No significant relationships were found between either demographic variable and scores on the Denver Developmental

Screening Test - Version II (DDST-II), Peabody Picture Vocabulary Test - Revised (PPVT-R-L), Developmental Test of Visual-Motor Integration (VMI) or Reynolds Depression Scales (RCDS and RADS).

The most common reasons for entering foster care included maternal substance abuse (54%), neglect (53%), abandonment (27%) and physical abuse (22%), as shown in Figure 3. It should be noted that multiple reasons for referral could be listed.

Fifty-one per cent of the children aged 2 months to 5 years were identified as in the "suspect for delay" range on the DDST II (see Figure 4). These findings are in stark contrast to normative data which suggest that 90% of children in this age group fall within the "normal" range (Frankenburg, Dodds, Archer, Bresnick, Maschka, Edelman & Shapiro, 1992).

On the Reynolds Depression Scales (RCDS and RADS), 11% of the 8-12 year-old group and 30% of the 13-19 year-old group reported significant depressive symptomatology (see Figure 5). The difference between age groups reached statistical significance [c2 (1, N=200)=11.08, p=.001]. The strength of the relationship between age group and depression was found to be moderate (r=.23).
Whereas the rate for the older group is disproportionately high when compared to normative samples, the percentage of children in the 8-12 year-old group identified as evidencing significant depressive symptomatology is comparable to percentages found in normative samples (Reynolds, 1987; Reynolds, 1989).

The lack of a significant relationship between depressive symptomatology and gender for both age groups was surprising [c2 (1, N=100)= 1.09, p = ns] in light of prior research documenting that girls tend to be more depressed than boys (Reynolds, 1987; Reynolds, 1989).

Based on PPVT-R-L results, 53% of children in the 8-12 year-old group and 64% of children in the 13-19 year-old group showed evidence of severe receptive language difficulties (see Figure 6). These figures are considerably higher than the 10% found in normative samples (Dunn & Dunn, 1981). No significant relationship was found between age group and scores on the PPVT [t(196)=.18, p= ns].

Both age groups demonstrated visual-motor integration skills that were closer to age expectation than were their receptive language skills (see Figure 6). However, children aged 13-19 still evidenced disproportionately high deficit rates, with 37% scoring below a standard score of 80 on the VMI&shyp;as opposed to 10% in normative samples (Beery, 1989). For children aged 8-12, 13% of the foster care sample scored below 80&shyp;as opposed to 10% in normative samples (Beery, 1989). Children aged 13-19 scored obtained significantly lower standard scores (M= 84) than children aged 8-12 (M=91.3)&shyp;[t(196)=4.20, p=.001].
Return to Top

Conclusion/Policy Recommendations

The present study describes the innovative mental health screening program implemented by Dale and Fogelman Associates in Baltimore. Preliminary research findings document the high rates of cognitive and emotional difficulties found among many of the children entering out-of-home placement/foster care.

The following policy recommendations flow directly from the major policy innovations that the Health Clinic has implemented in Baltimore:

1. Centralized Screening Programs - In metropolitan areas, centralized clinics administered in conjunction with the local social service agency can ensure cost-efficient screenings. In suburban/rural areas, several identified medical practitioners may need to "share" one mental health practitioner who can perform screenings on-site for the purpose of generating consolidated health information for children entering foster care.

2. Consultation Programs - Mental health consultations should be conducted by clinic staff for social services workers. Such consultations can prove invaluable in clarifying recommendations and providing assistance in difficult cases.
3. Computer Tracking - Both centralized and non-centralized programs can benefit from a common computerized tracking system. This database should include the following critical information on each child: placement, current health status, major recommendations (including need for follow-up), guardians, and the particular social service unit to which the child's case is being transferred. Such a database can also facilitate in-house record keeping regarding proficiency in foster care placement and follow-up.
4. Provider Forums - Mental health providers, in conjunction with their medical counterparts, should confer with community practitioners who typically service children once they enter foster care. The overriding need for "continuity of care" suggests that provider forums can (1) help clarify the policies of the screening clinic; (2) smooth transitions for children as they move in and out of the foster care system; (3) arrange for the pooling of data; and (4) "bond" clinicians in the common cause to serve at-risk children. In non-urban areas, bi-annual meetings may be preferred, especially if local practitioners know each other well. The importance of forums designed to oversee the delivery of services to children in foster care should not be underestimated.
5. Program Linkages - Mental health providers need to forge liaisons with Head Start, pediatric HIV programs, and other public and private child advocacy groups. Program linkages are especially important in removing bureaucratic barriers that impede service delivery to children.

Return to Top

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Return to Top

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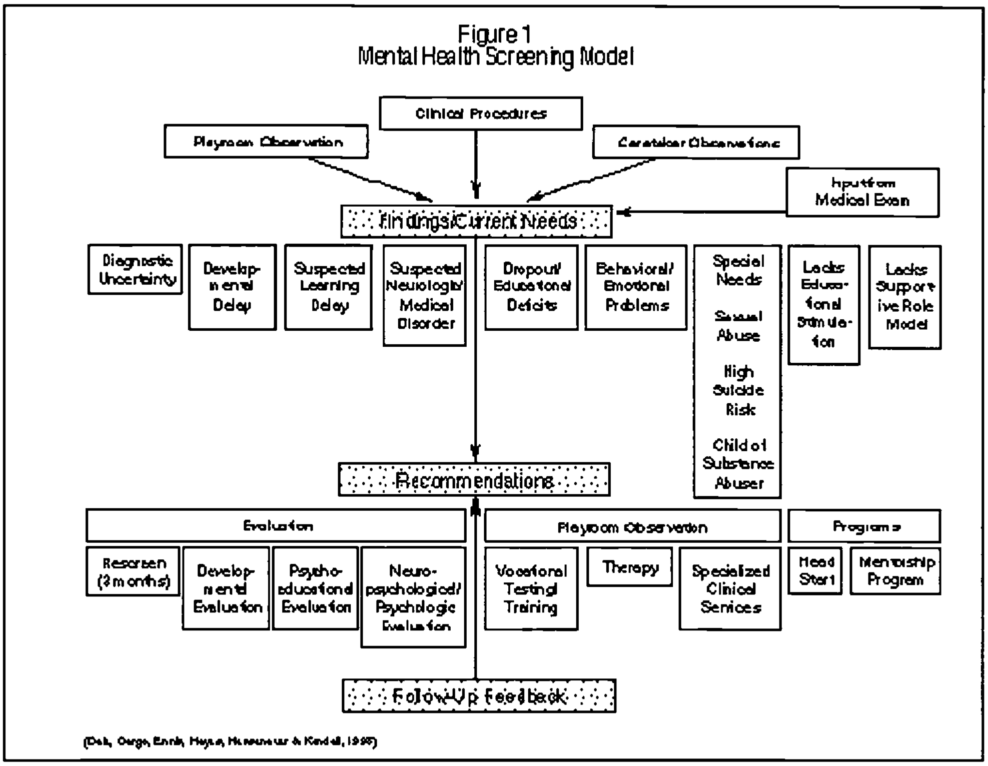
Return to Top

[Home] [Search] [Index]

Figure 1

Return to Article



[Home] [Search] [Index]

Table 1

Return to Article

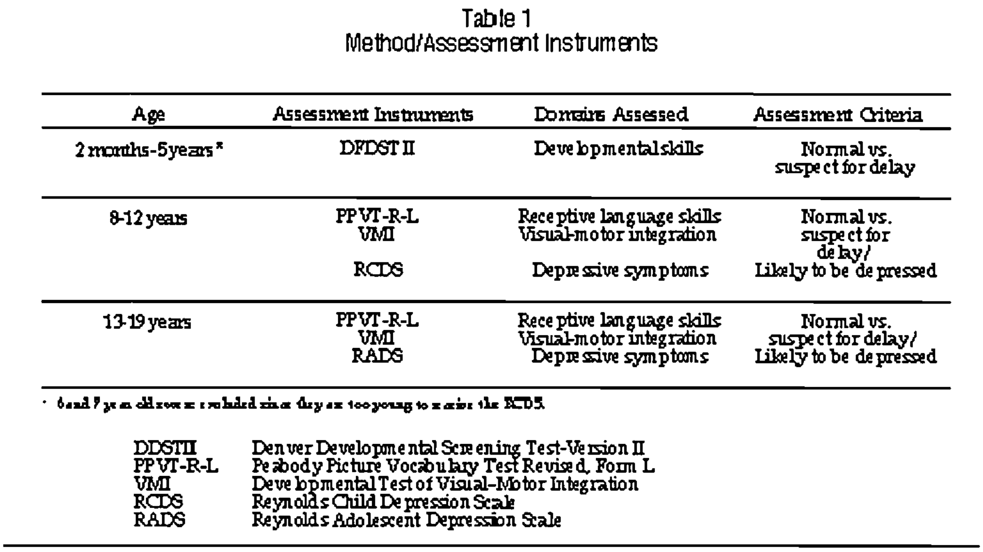


Table 1
Method/Assessment Instruments

Age	Assessment Instruments	Domains Assessed	Assessment Criteria
2 months-5 years*	DFDST II	Developmental skills	Normal vs. suspect for delay
8-12 years	PPVT-R-L VMI RCDS	Receptive language skills Visual-motor integration Depressive symptoms	Normal vs. suspect for delay/ Likely to be depressed
13-19 years	PPVT-R-L VMI RADS	Receptive language skills Visual-motor integration Depressive symptoms	Normal vs. suspect for delay/ Likely to be depressed

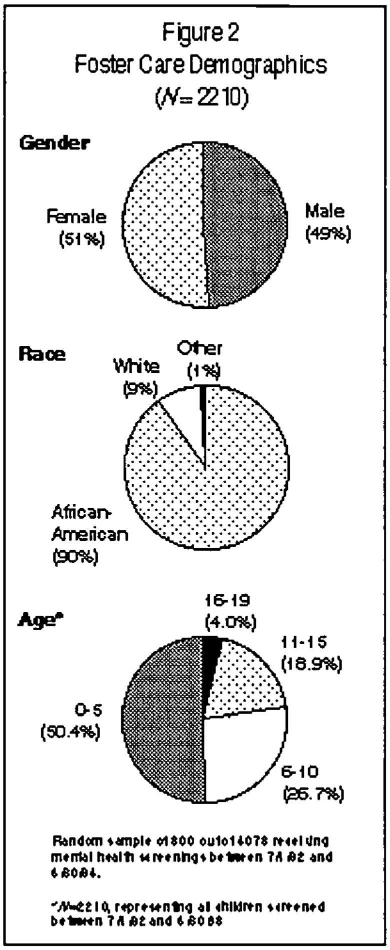
* 6 and 7 year olds were excluded since they are too young to receive the RCDS.

DDSTII	Denver Developmental Screening Test-Version II
PPVT-R-L	Peabody Picture Vocabulary Test Revised, Form L
VMI	Developmental Test of Visual-Motor Integration
RCDS	Reynolds Child Depression Scale
RADS	Reynolds Adolescent Depression Scale

[Home] [Search] [Index]

Figure 2

Return to Article

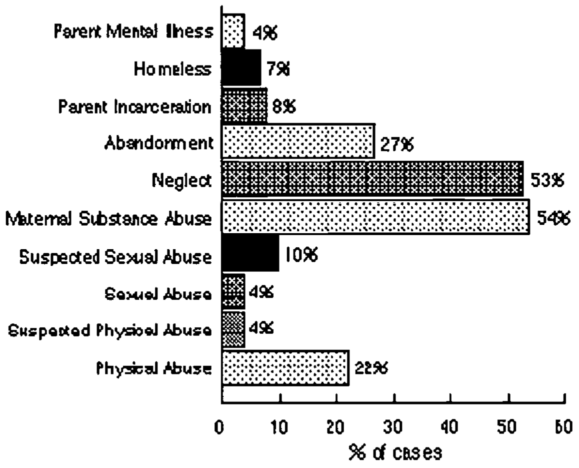


[Home] [Search] [Index]

Figure 3

Return to Article

Figure 3
Reasons for Entering Foster Care *
(*N* = 300 Case Records) †

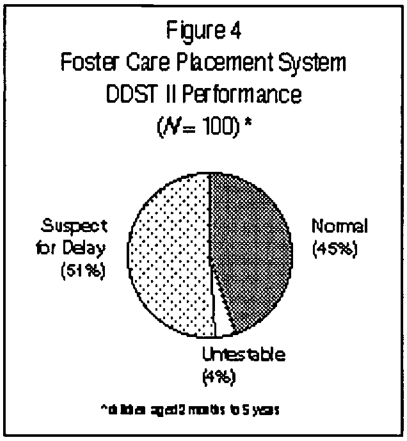


* Note: Many of the case records revealed multiple reasons why children were entering the Foster Care System. For example, Maternal Substance Abuse was often stated with Neglect and Abandonment.

† Note: Random Sample from 4073 Children Receiving Mental Health Screenings Between 7/1/92 and 6/30/94

[Home] [Search] [Index]

Figure 4
Return to Article



[Home] [Search] [Index]

Figure 5

Return to Article

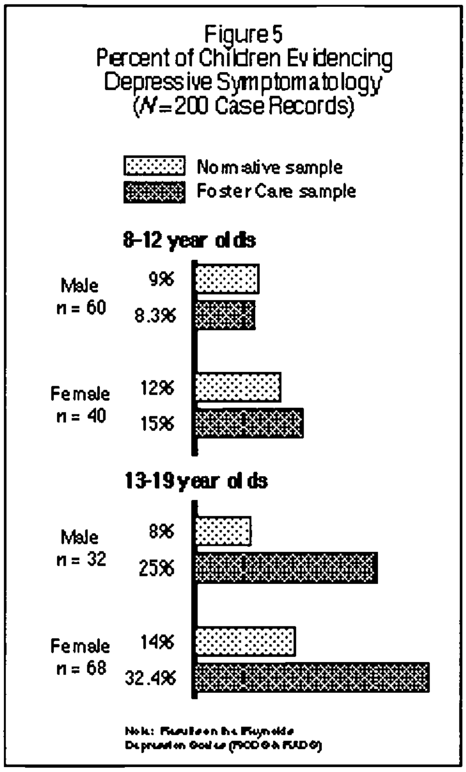


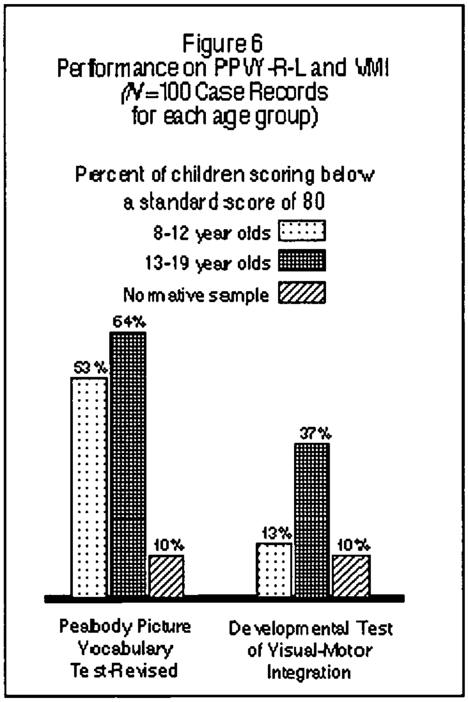
Figure 5
Percent of Children Evidencing Depressive Symptomatology (*N*=200 Case Records)

Note: Results on the Reynolds Depression Scales (RCDS & RADS)

[Home] [Search] [Index]

Figure 6

Return to Article



[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Delinquency and Mental Illness: The Intersection of Problems and Systems

Authors

Introduction Method Results Discussion References

Return to Table of Contents

Introduction

The complexity of the emotional and behavioral problems youth experience thwart efforts to develop integrated and coordinated systems of care for children and adolescents (Duchnowski, Johnson, Hall, Kutash, & Friedman, 1993). The difficulties of helping youth with multiple problems may be compounded when the problem set includes behaviors that span the mental health system and the juvenile justice system, specifically. Studies of the general population of adolescents show delinquency and mental disorder co-occur (e.g., Elliott, Huizinga, & Menard, 1989). Few studies, though, have estimated the proportion of youth referred to juvenile courts in need of mental health services or the proportion of mentally disordered juvenile offenders in mental health placements (Fagan, 1991). This summary explores (1) the prevalence of delinquency among youth referred for services within the mental health system, (2) the co-occurrence of delinquency and mental disorder, and (3) the prevalence of official delinquency as indicated by involvement with the juvenile justice system.

Return to Top

Method

Sample

Data were obtained through the Fort Bragg Evaluation Project (FBEP), an evaluation of a model mental health service system for children and adolescents (see Bickman, Guthrie, Foster, Lambert, Summerfelt, Breda, & Heflinger, 1995, for more details on the evaluation and the model service system). The sample included children and adolescents ages five through seventeen who were referred for formal mental health services at the time they entered the study. On average, youth were about 11 years old, and about 60% were male. Seventy percent were white; about 20% African American; and 10% were of other or mixed race/ethnicity. Less than half of the sample lived with both biological parents, though 80% lived in a two-parent household (e.g., with a biological and stepparent). Most of the families earned between twenty and forty thousand dollars annually. The sample's average standardized scores on the Child Behavior Checklist (CBCL) and Youth Self Report (YSR) were very similar to those reported by Achenbach (1991) and Achenbach and Edelbrock (1993) for other clinical samples of youth. Thus, findings from this research may apply to other populations of roughly middle-class youth referred for mental health services (see Bickman, et al., 1995, for more details on the representativeness of the sample).

Measures

Delinquency. The CBCL's (Achenbach, 1991) standardized narrow-band scale score on the delinquency syndrome measures level of delinquency-related problems1. Cutoff points for the scale also indicate whether youth fell into the borderline/clinical range (hereafter, clinical), or the nonclinical range. Official delinquency refers to contact with the juvenile justice system; that is, whether youth either had been picked up or arrested by police, punished or adjudicated by a court, placed on probation, or incarcerated.

Mental Disorder/Psychopathology. Seven standardized CBCL scales-p;withdrawn, somatic complaints, anxious/depressed, social problems, thought problems, attention problems, and sexual problems-p;measure level of psychopathology2. Again, cutoff points for each of the seven scales indicate whether youth fell into the clinical or nonclinical range for each problem area. An overall psychopathology measure identifies youth who fell into the clinical range for any of the seven syndromes.

Return to Top

Results

Delinquency
Table 1 shows the sample's average T-score on the delinquency syndrome was 64.4. Forty-seven percent of the youth fell into the clinical range. Nearly one-fifth (18%) of the youth had contact with the juvenile justice system, a rate roughly six times that found in the general population (U.S. Department of Justice, 1991). As expected, age and delinquency positively correlated, with regard to delinquent symptomatology and official delinquency. Particularly, delinquency and legal contact increased dramatically among older adolescents 12 to 17 years of age. Males also were significantly more likely than females to have had contact with the police or courts. Contrary to the delinquency literature (e.g., Elliott, et al., 1989), however, they showed lower levels of delinquency-related problems than females. African Americans, too, showed lower levels of delinquency than either Whites or youth of other races. These findings may reflect a selection bias, in that more seriously delinquent males and African Americans may be less likely to receive services within the mental health system than to be referred to the juvenile justice system, compared to females and White youth.

Return to Top

Mental Disorders

Table 2 shows the proportion of youth in the clinical range on each of the narrow-band syndromes. Considering the seven measures of psychopathology, 70% of the youth experienced clinical levels in at least one area. Forty-one percent of youth manifested clinically-significant levels of aggressiveness. However, more youth reported serious delinquency (47%) than any other type of problem. All nine syndromes considered, 80% of the sample reported clinical levels in at least one problem area 3.
Co-occurrence of Delinquency and Mental Illness
Table 3 presents the zero-order correlations between the delinquency scale score and the seven psychopathology scale scores. The data show higher levels of delinquency associated with higher levels of psychopathology. While all the relationships are statistically significant ($p < .01$), the magnitude of the correlations is rather modest. Nearly all are .4 or less. In general, these findings suggest a moderate relationship between levels of delinquency and psychopathology.

Another way to assess co-occurrence of delinquency and mental disorder is to identify the proportion of youth with clinical levels of symptomatology in both areas. Table 4 shows that 39% of the youth experienced clinical levels of delinquency-related problems as well as clinical levels in at least one of the seven areas of psychopathology. At the same time, a nearly equal proportion (31%) had more focused problems of the type mental health services were traditionally designed to address.

A closer view of these data further highlights the nature of the relationship between delinquency and mental disorder. Among youth with serious levels of psychopathology (70%), 56% also indicated a clinically-significant level of delinquency. The problems of the other 44% remained more circumscribed to some type of mental disorder only. The picture changes considerably, though, when one considers those youth referred for services with serious delinquency-related problems (47%). Among these youth, a large majority (83%) also had clinically-significant psychopathology. The pervasiveness of these youth's problems is further indicated by the fact that youth with clinically-significant delinquency problems reported clinical levels in an average of 3.3 areas of psychopathology while those with a nonclinical delinquency profile experienced serious levels in 1.6 areas of psychopathology. So, while

delinquency and mental disorder are only moderately related, when delinquency occurs, it is very likely to be accompanied by severe psychopathology in multiple problem areas.
Return to Top

Discussion

The co-occurrence of mental illness and delinquency, specifically, raises special concerns for the mental health field. The large and growing numbers of comorbid youthful offenders within the mental health system, and the pervasiveness of their prob-lems, challenge the way we develop, structure, and deliver services to this group of youth. Programs within the mental health system have been traditionally designed for troubled youth, not troublesome youth. The findings presented here suggest that clinicians may need to anticipate that over half of their clients may not only have some psychopathology, but may also be disruptive, perhaps violent, and difficult to control.

The task of providing appropriate care is made more difficult by the fact that relatively large proportions of youth in the mental health system have been involved in the juvenile justice system as well. Developing a service system for troubled and troubling youth requires integration of more than the typical child-helping systems (e.g., education, social services). It also requires incorporating the juvenile justice system, a system that unlike other child-serving systems, has increasingly responded punitively rather than rehabilitatively toward youth (Schwartz, 1989). Problems of system integration and the development of effective services extend beyond these philosophical differences between systems. Pragmatic issues of system boundaries, perceived scope of responsibility, and financing structures continue to thwart efforts to integrate service systems for children and adolescents (Duchnowski, Johnson, Hall, Kutash, & Friedman, 1993; Fagan, 1991).

The overlap between mental disorder and delinquency, indicated by the findings here, also calls into question the criteria for placing youth in either the mental health or juvenile justice system. Some evidence suggests, for example, that personal traits such as sex and race predict system placement more reliably than psychopathology (Westendorp, Brink, Robertson, & Ortiz, 1986). The juvenile justice system has long been prey to charges of discrimination. The mental health system, with some historical exceptions, has been less a target for such claims. This situation may change as the types of problems that define youth in need of mental health treatment and eligibility for reimbursement expand, such as in the case of substance use (Schwartz, Jackson-Beeck, & Anderson, 1984; Staples and Warren, 1988).

The development of a service system that can adequately attend to the needs of youth who demonstrate levels of delinquency-related problems more severe than 95% of their peers in the general population remains a serious challenge for policy makers, program planners, and clinicians. Moreover, we must also recognize that the juvenile justice system must be counted among the institutional actors that represent a comprehensive system of care for children and adolescents (Stroul and Friedman, 1986). Efforts to develop this integrated system, finally, cannot be divorced from larger issues of social justice and equity.
Return to Top

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Return to Top

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1 The delinquency syndrome scale is based on 13 items, 7 of which refer to legally proscribed behavior (e.g., running away, arson, stealing at home, stealing outside the home, truancy, substance use, and vandalism). Three other items refer to nondelinquent behavior (swears, lies/cheats, associates with troublemakers). Three others refer to attitudes or thought processes (feels no guilt after wrongdoing, prefers older companions, and thinks about sex too much). Thus, the delinquency measure used in this research is not based solely on delinquent conduct. However, empirical analyses have repeatedly found that these thirteen items correlate and load on a single "delinquency" factor (Achenbach, 1991). Further, preliminary analyses of the FBEP data show that over 80% of youth with clinical levels of delinquency also report engaging in legally proscribed behavior. These findings support the validity of using the delinquency syndrome score as a surrogate for delinquency.

2 For this research, the author does not consider the aggressiveness syndrome a measure of psychopathology. It more resembles delinquency: it includes three items that refer to legally proscribed behavior (i.e., destroying others' property, fighting, and physically attacking other people) and highly correlates with delinquency (r = .71).

3 That 20% did not report a clinical level on any of the CBCL measures does not necessarily mean some youth were receiving mental health services inappropriately (Achenbach, 1991).

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies,
Florida Mental Health Institute, University of South Florida,1996

Assessing The Mental Health of Adolescents in the Mental Health and Juvenile Justice Systems

Authors

Introduction Method Results Discussion References
Return to Table of Contents

Introduction/Purpose

The purpose of the present study is to describe the mental health functioning of youth involved in the mental health and juvenile justice systems. Self-report information is derived from the Millon Adolescent Clinical Inventory (MACI; Millon, 1993), which gives diagnostic impressions and personality descriptions, as well as from the Trauma Symptom Checklist for Children (TSCC; Briere, 1989), which gives information about trauma related symptoms and post-trauma functioning. Caregivers report impressions of behavior and emotional functioning using the Child Behavior Checklist (CBCL ; Achenbach, 1991).

Return to Top

Method/Procedure

Two self-report instruments&shyp;the MACI and TSCC&shyp; were administered to 13 male adolescents incarcerated in a juvenile justice facility (Group I) and 13 male adolescents served by intensive-in-home wrap-around services (Group II). The CBCL was completed by caregivers for both groups.

There were no statistically significant differences in age or race between the two groups. The mean age for the two groups was 15.5 years for Group I and 14.5 years for Group II ($t = 0.23$, $df = 24$, $p = NS$) with a total range of 13 to 17 years. The racial distribution was: 3 African-American, 10 Caucasian for Group I and 1 African-American, 12 Caucasian for Group II ($c2 > 0.295$, $p > .05$).

Additionally, a demographic coding sheet was completed on all subjects by the investigators. Demographic data was obtained from juvenile justice and mental health databases which included child, family and academic information. Youth were comparable on age, race, gender, and on mental health as well as juvenile justice issues.

Return to Top

Results

Results on the MACI suggest that youth in the juvenile justice system expressed significantly more mental health concerns than did the youth in the mental health system. Overall, youth in Group I displayed elevations on 11 scales while those in Group II were elevated on 8 scales. Five areas of significant differences between the two groups were found. Significant differences were in the direction of Group I. (see Figure 1) Significantly elevated scores on MACI scales included Doleful, Desirability, Childhood Abuse, Substance Abuse Proneness and Anxious Feeling.

It is also important to note that no differences were found between the groups on MACI scales measuring Depressive Affect, Suicidality or Delinquent Predisposition. Also, groups were comparable on the TSCC scales measuring Anxiety, Depression, Post-traumatic Stress, Sexual Concerns, Dissociation and Anger.

Many significant differences were found between the caregivers' ratings on the CBCL for the two groups. However, the differences are difficult to interpret. The validity of observations reported for Group I are questionable. Observations for Group II showed a strong relationship to youth-reported concerns on the MACI.

Return to Top

Implications

The present study identifies the mental health concerns of a small number of youth involved in the mental health and juvenile justice systems. The study directly measures the concerns of youth in each system. Differences as well as similarities describe mental health concerns in the juvenile justice involved youth. Understanding the breadth of the juvenile justice involved youth's mental health needs may facilitate the development of an array of services addressing the physical, emotional, social and educational needs of the adolescent and his/her family.

Two major shortcomings of the study are its small sample size and possible group difference resulting from subject selection procedures. Youth in the juvenile justice group resided in an institution, while youth in the mental health group resided at home and were served by community-based interventions. The mental health group is the most comparable group available in the public mental health system in Ohio, but group differences resulting from the effect of institutionalization may account for the study's findings. Further cross-system work is needed.

Return to Top

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Return to Top

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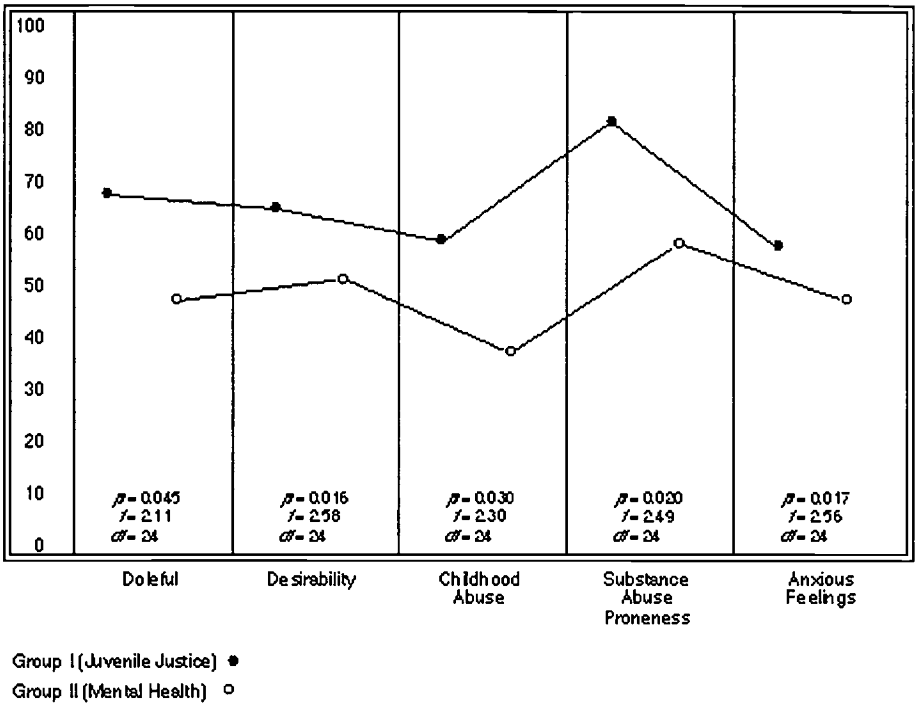
Return to Top

[Home] [Search] [Index]

Figure 1

Return to Article

Figure 1
MACI Significant Differences



[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies,
Florida Mental Health Institute, University of South Florida,1996

Psychopathology and Symptomatology in Incarcerated versus Hospitalized Youth

Authors

Introduction Method Results Discussion References
Return to Table of Contents

Background

The problems of juvenile crime and the incarceration of youth are receiving increasing attention nationally. These are particularly critical problems in South Carolina, which already has the highest rate of incarceration of any region in the free world (Corrections Compendium, 1991; Fowler, 1991). The South Carolina Department of Juvenile Justice (DJJ) has a daily census of 800 to 1000 youth incarcerated in its facilities in Columbia and serves over 3000 youth annually. It is currently facing a lawsuit in federal district court involving overcrowding of its facilities and the care of juvenile offenders that have emotional disturbances or mental illness.

The fact that youth with mental illness are being incarcerated at all brings up serious concerns about the failure of community services designed to prevent such outcomes (Duchnowski, Johnson, Hall, Kutash, & Friedman, 1993). The lack of community-based and preventive mental health services for youth, particularly in rural areas, allows many youth with emotional or mental disorders to go undetected and untreated to the point that they suffer from disruptive behavioral symptoms and come to the attention of juvenile authorities and family courts. These factors may account for the over-representation of African-American youth in the incarcerated juvenile population (Cohen, Parmelee, Irwin, Weisz, Howard, Purcell, & Best, 1990). There may be a number of factors involved in the over-representation of minority youth in incarcerated populations including: the failure of mental health and social services to address the needs of minority youth (Mason & Gibbs, 1992) and biases in assessment (Fabrega, Ulrich, & Mezzich, 1993) which may predispose the entry of minority youth into the juvenile correctional system.

To date, there have been no systematic studies in the U. S. addressing the problem of incarceration of youth with emotional disorders/mental illness. The few studies conducted have not used systematic diagnostic instruments to evaluate such disorders and have not examined factors leading to incarceration. Those conducted so far indicate that a major proportion of incarcerated juvenile offenders have significant mental/emotional disorders (Hollender & Turner, 1985; McManus, Alessi, Grapentine, & Brickman, 1984).

Specific Aims

This project addresses a number of important questions underlying the incarceration of youth with mental/emotional disorders. These include: (1) What is the prevalence of major DSM III-R diagnoses amongst incarcerated versus hospitalized youth? (2) What is the symptomatic prevalence (mean symptom count) across the two groups? (3) What are the levels of behavioral symptomatology (as measured by CBCL and YSR) across the two study groups?

Return to Top

Methodology

Subjects
We recruited youth from the midlands region of South Carolina, ages 13-17, including youth hospitalized at the William S. Hall Psychiatric Institute (which serves youth from most of the state) and incarcerated youth recruited from DJJ in Columbia. Hospitalized youth were randomly selected from new admissions, while incarcerated youth were randomly selected from institutional rosters. The counties included in the study represent a balance of rural and urban populations. Youth with an IQ of 65 or below were excluded from the study. Sample demographics were as follows: mean age = 14.9 (hosp.), 14.4 (DJJ); gender = 55% male (hosp.), 94% male (DJJ);
race = 52% African-American and 48% Caucasian (hosp.),
68% African-American and 32% Caucasian (DJJ).

Instruments
DISC-PC, version 2.3 (Diagnostic Interview Schedule for Children). This structured diagnostic interview was used to determine diagnoses as well as symptoms of mental/emotional disorders. It was administered by psychiatric social workers, nurses and physicians (Shaffer, et al., 1993).
Child Behavior Checklist. This instrument was used to obtain parent ratings of behavioral and emotional symptoms (Achenbach, 1991).

Services History Form. The Services History Form was developed and administered as a standard instrument, completed by the parent to document and code categories of health, mental health (outpatient and acute hospitalization), residential, educational, social, and volunteer (Boy/Girl Scouts, Big Brother/Sister, etc.) services provided for each youth. This instrument was patterned after that described by Hinkle (1992), in use at the South Carolina Continuum of Care. Parents were asked to rate the value of this service, the age of the youth when the service was used, the service's duration, and frequency.

Procedure
Youth and their parents/guardians were recruited to participate in the study and written consents were obtained. The parent behavior rating scale (CBCL) was completed either in person or by mail. If the parents were unable to read they were provided assistance. The youth were then interviewed by trained professionals (clinical psychiatric social workers and nurses).

Return to Top

Results

We are currently reporting on preliminary findings based on 31 hospitalized and 31 incarcerated youth studied to date. On the DISC 2.3, we found that 79% of the hospitalized youth and 71% of the incarcerated youth met diagnostic criteria for at least one disorder. There was a high rate of comorbidity in both samples, with a mean of 3.1 diagnoses per youth in the hospital sample and 2.4 diagnoses in the incarcerated sample&shyp;these differences in rates between the two samples were not statistically significant ($t = 0.93$, $p > 0.20$). Levels of symptomatology were also quite high in both samples, with a mean of 43.8 positive symptoms in the hospital sample and 30.4 symptoms in the incarcerated sample&shyp;a difference of marginal significance ($t = 1.95$, $p < .10$).

Using the CBCL, we found greater differences between the two groups. The mean total T score (72.8), the mean internalizing T score (70.4), and the mean externalizing T score for the hospital sample (70.0) were higher than for the incarcerated sample (mean T total = 61.8; mean internal T = 56.8, mean external T = 63.2; total T: $t = 4.62$, $p <. 001$; internal T: $t = 4.84$, $p < .001$; external T: $t = 2.77$, $p < .01$). In the hospital sample, 93% met the 60+ cutpoint total problem T score suggested by Achenbach (1991). In the incarcerated group, 60% met the 60+ cutpoint. Additional analyses along racial/ethnic lines indicate that hospitalized African-American youth (N = 15) had much higher mean number of diagnoses (3.56), mean symptom counts (50.8) and percent caseness (88%) than Caucasian youth who were hospitalized (N = 15, mean dx. = 2.46, mean sx. ct. = 35.3, and percent caseness = 69%); while incarcerated African-American youth had slightly lower levels of psychopathology (N = 21, mean dx. = 2.21, mean sx. = 29.2, percent caseness = 69%).

The overall levels of service utilization were found to be somewhat higher in hospitalized (mean = 7.90)

versus incarcerated youth (mean = 5.55; t = 1.76, p < .20). Levels of educational and volunteer services were similar (hospitalized youth: mean educational services = 1.63, mean volunteer services = 0.90; Incarcerated youth: mean educational services = 1.32, t = 1.49, p < .20, mean volunteer services = 0.71, t = 0.60, p > .20&shyp;non significant). Incarcerated youth actually had higher levels of previous out-of-home residential services (residential, foster care, group home;
mean = 1.32) as compared to hospitalized youth (mean = 0.71; t = 2.22, p < .05). However, they had lower levels of previous mental health services (mean = 1.19) as compared to hospitalized youth (mean = 2.46; t = 3.05, p < .01). In examining cross-ethnic differences, we found that African-American hospitalized youth used equal levels of mental health services as Caucasian youth, but had higher levels of special school services (53% using additional school services) as opposed to Caucasian hospitalized youth (20%), higher levels of residential services (mean = 0.87) than hospitalized Caucasian (mean = 0.47), but equal residential services as incarcerated African-American youth (mean = 1.00).

Return to Top

Conclusions

Levels of psychopathology and symptomatology are lower in incarcerated youth as compared to hospitalized youth. However, their levels of symptomatology and psychopathology are quite significant as compared to expected general population rates. This strongly indicates the appropriateness of high levels of mental health services to address the needs of incarcerated youth. In addition, the findings do not support the common assumption that incarcerated youth receive significantly fewer services than other youth. However, it is important to note that incarcerated youth have received lower levels of mental health services while receiving higher levels of out-of-home services. A tentative hypothesis coming out of our findings is that more frequent use of outpatient mental health services, perhaps at a younger age, might result in youth being served more readily in the mental health versus the juvenile justice system. Another tentative hypothesis is that minority youth may travel a parallel service pathway from school or social services into the juvenile justice system which does not often intersect with mental health services. Continued analysis on the complete cohort will investigate racial/ethnic factors in service utilization and age of entry into the mental health system across the two groups.

Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

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Boot Camp: Is It Working?

Authors

Introduction Method Results Discussion
Return to Table of Contents

Background

The Pinellas Boot Camp Initiative in Pinellas County, Florida, is a complex juvenile justice program characterized by a high degree of interagency collaboration, strong involvement of community leaders and policy makers, and an emphasis on family involvement. It is the first program of its kind in Pinellas County and one of the first programs in the country to utilize the boot camp model for juvenile offenders.

The interagency service delivery model was designed to address concerns about increases in juvenile crime and recidivism with innovative solutions. Partners in this effort include the Pinellas County Sheriff's Department, the Pinellas County School Board, District V Juvenile Justice Program (JJ), Eckerd Family Youth Alternatives (EFYA), and the Juvenile Welfare Board of Pinellas County (JWB). The Advisory Group includes leadership from the County Commission, Office of Justice Coordination, and the Judicial system. The Juvenile Welfare Board's Research & Development Center is conducting a comprehensive evaluation of the Initiative to determine the profiles of the youth for whom this program is effective in terms of recidivism, their personal growth and public safety.

The Pinellas County Boot Camp Initiative serves juvenile offenders (ages 14-18) and their families. Screening criteria were established by the Juvenile Justice Act. Eligible youth are those committed to level 6 and level 8 programs who are physically and mentally able to participate. The program includes a four month residential commitment phase (Pinellas County Boot Camp), where youth confined to the Boot Camp undergo intensive physical training, education and counseling; an eight month intensive aftercare commitment phase (Eckerd Leadership Program), where youth continue activities which now include restitution, career development, job training and employment in an increasingly less structured setting; and twelve months of voluntary follow-up. Family support services are provided to families of recruits during the entire Initiative.

The Pinellas County Boot Camp serves the Juvenile Justice West commitment service region, which includes Pinellas, Pasco, Hillsborough, Polk, Highlands, Hardy, Manatee, Sarasota, Lee and Collier Counties. The Eckerd Leadership Program (ELP) serves only youth and families living in Pinellas County. Recruits from other counties are transferred to aftercare programs in their county of origin.

Return to Top

Method

A comprehensive interagency data base and data management agreement were developed during the start-up year. The data base will be utilized in 1995-96 to track program outcomes and look for predictive factors, such as individual youth characteristics or patterns of offense history, which may be associated with successful program completion and positive outcomes. Other assessments have included personal interviews with recruits and staff at both facilities, timed observations, and regular data collection from all collaborators about the youth and their progress in the Initiative.

The creation of the new Florida Department of Juvenile Justice and associated changes in legislation and funding will have long lasting impact on many aspects of the Boot Camp Initiative. The most significant short-term impact was a delay in funding for full implementation of the Aftercare phase.

Funding for the residential program at the Boot Camp was not affected when responsibility was transferred to the new Department on July 1, 1994. In addition, the Boot Camp, which opened in November, 1993, was past the start-up period with most planned interventions in place when the change occurred. By contrast, the ELP Aftercare program, which opened on March 29, 1994 with start up funds from the Juvenile Welfare Board, did not have an established contract with the state's Department of Health and Rehabilitative Services to transfer to the Department of Juvenile Justice on July 1, 1994. Although the day program and some support services were provided, evening and weekend hours and the hiring of additional staff at the Aftercare site were delayed through the Fall of 1994. This resulted in less intense supervision of youth during the community phase than had been planned, and delayed implementation of some Aftercare programs and services. Full funding has now been approved, and the Aftercare component is moving towards full implementation.

The collaborative program model is designed to provide comprehensive services to respond to complex needs. Program strategies include provision of structure and discipline combined with appropriate role modeling, individualized planning, supervision and family involvement to increase youths' pro-social behavior and reduce delinquency. Interagency communication and coordination are viewed by all participating agencies as essential to successful outcomes. Progress has been made to establish continuity and commonalties among all program components.

An interagency planning and evaluation process has supported this effort. Continued attention to integration of program components is recommended, as is periodic interagency review of the conceptual framework and program goals.

Return to Top

Findings

Data collected during the first year of the program show that youth admitted to the Boot Camp have diverse needs. Many have experienced disruptions in family life and have had poor school adjustment. More than half of all recruits have special education needs. Many have had several prior referrals into the juvenile justice system and have been in other commitment programs. Appropriate home placement during aftercare has been an issue for several youth, especially those who had been living in foster care or other non-family settings prior to commitment. Comprehensive evaluation of individual risks and needs has not always been available prior to placement in the residential Boot Camp program.

Program completion data are available for all recruits admitted to Pinellas County Boot Camp, and for Pinellas County youth who transitioned to ELP Aftercare. Completion data is not available for youth who reside in other counties but will be included in the next semi-annual report. Recidivism rates and other outcome data were not computed because some phases of the program have been in operation for less than a year. Preliminary outcome data will be included in the semi-annual report. Because of changes in program eligibility, program modifications during the start up period and unexpected delays in implementing some aspects of the program, results for the first several platoons will be analyzed separately.

Return to Top

Discussion

Other evaluation issues to be addressed during the next period include utilization and impact of "recycling" youth who engage in risk taking behavior back to Boot Camp from aftercare, criteria for "readiness" of youth to transition from Boot Camp to a community setting and analysis of educational progress and outcomes during all program phases.

Results to date are inconclusive. However, it is the expectation of the researchers that the next report on this Initiative will have preliminary information about the profiles of youth who most benefit from this program.

Return to Top

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Return to Top

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies,
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Providing Intensive Child Case Management Services: What Do Case Managers Do with Their Time?

Authors

Introduction Methods Results Discussion References
Return to Table of Contents

Introduction

Within the past two decades, several trends have been instrumental in affecting the policy and intervention for families with children who have severe emotional and behavioral problems. In particular, the trends towards deinstitutionalization, family preservation, family reunification, and parent-professional collaboration have been synthesized to provide a coordinated systems policy to guide state mental health practice (e.g., Behar, 1988; Burchard, et al., 1991; Homonoff & Maltz, 1991). One key aspect of the emerging systems of care is the creation of family strengths and community based intensive child case management services. In an effort to increase our understanding of the factors associated with the successful implementation of family strengths based intensive case management services, this summary will focus on the results of an exploratory study, conducted to describe the efforts of one rural state's implementation of a family-strengths, community based intensive case management program (ICM) for families with children with severe emotional and behavioral problems.

Return to Top

Methods

An in-depth, systematic review of ICM case records was undertaken for the purpose of: (a) delineating characteristics of the children and families being served; (b) identifying service needs and barriers; (c) describing the amount and type of contact between case managers and families and other service providers; and (d) examining the relationship between case managers' contact with families and providers, and characteristics of the families and children being served.

Program Description

This study was conducted following the first year of implementation of a state wide intensive child case management services. The intensive child case management services are part of a continuum of child and adolescent mental health services developed and implemented by the State of Maine Department of Mental Health and Mental Retardation. This continuum of services (e.g. child case management, crisis services, community-based residential services, etc.) was legally mandated following agreement of a class action suit between mental health consumer groups and state mental health and human services officials, resulting in a substantial decrease in the number of state hospital beds for adults, a virtual elimination of state hospital beds for children and adolescents, and increased funding allocations for improving and expanding community based mental health services.

Six agencies were awarded two year contracts with the state department of mental health to provide intensive child case management services. Three of the agencies are community mental health centers, and three are private, non-profit child and family services agencies. There are a total of 13 child case managers employed throughout these six agencies, with each case manager expected to carry a caseload of 15 families with children with severe emotional and behavioral disabilities.

Return to Top

Population and Sample

The population consisted of the case records of all Maine children and adolescents who received Intensive Case Management (ICM) services from the initial start of the program in April, 1991 through June, 1992 (approximately 150 children). Based on discussions with state department of mental health staff, case managers and agency administrators, and the review of the literature on children with severe emotional and behavioral difficulties [e.g., Lourie, et al (1990); Ronnau, (1992); Stroul & Friedman, (1986)], a purposive sample of 50 case records was chosen for review in order to compare across several categories of records: children involved in a state class action consent decree (20), children involved in the class action consent decree who were also in the custody of the department of human services (5), children who were psychiatrically hospitalized while receiving ICM services (10), children who remained in the community (without a more restrictive placement) while receiving ICM services (6), and children who were under the age of 12 when they began receiving ICM services (5). Each ICM Program supervisor randomly chose five cases for review, one case for each of the five categories. Sixty-eight percent (34) of case records involved boys; 32% (16) involved girls. The mean age for the children and youth was 13.42 years (SD: 2.88 years), with a range from 4 to 17 years. Of the 41 records noting the child's grade level, the mean grade level was 7.52 (SD: 2.61). The majority of the children and youth were White (88%, n=44), with 6% (3) Native American children and 6% (3) African American children.

Procedures and Data Analysis

Case records were reviewed by either the principle investigator or one of two graduate social work research assistants who had been trained by the PI. Three protocols were used in the review of the case records. First, the Child Case Management Case Record Review Protocol (developed by the principle investigator) consisted of a series of 18 close-ended questions related to child and family demographics, referral sources, family structure, and child's place of residence, and 27 open-ended questions on topics such as service needs, family background, child problems, and family strengths. Second, a revised version of the Vermont Restrictiveness of Living Scale (Burchard et al., 1991), was also completed for each case review, creating a graph of the number and type of placements experienced by the child from birth to the present review. Third, the Child Case Manager Contacts Protocol (developed by the principle investigator) provided a mechanism for recording case managers amount of contact (in hours), with whom (e.g., child, family, child therapist etc.), and the type of contact noted in each case record (direct, telephone, meetings, other). Each Child Case Management Case Record Review Protocol was read by the principle investigator and the two research assistants in order to look for emergent themes. Content analysis, based on the frequency with which themes were present in the protocol, was then conducted.

Return to Top

Results

Child Characteristics

At the time of referral to ICM 46% (23) of the children and youth resided with their families, 14% (7) were psychiatrically hospitalized, 12% (6) were in foster care, 12% (6) resided in an in-state residential treatment center (RTC), 10% (5) were at the Juvenile Detention Facility, 2% (1) lived in a therapeutic foster home, out of state RTC (2%, n=1), or a friend's house (2%, n=1). Birth parents were overwhelmingly the guardian of the children and youth at the time of referral (70%, n=35), followed by the department of human services (20%, n=10), and the child's adoptive parents (10%, n=5).

Families were most frequently referred for ICM by the state department of mental health (32%, n=16), department of human services (18%, n=9), psychiatric hospitals (16%, n=8), and local crisis intervention services (8%, n=4). Families waited a mean of 9.60 months (SD: 4.72 months; range: 0-18 months) from the date of referral for ICM services to the actual introduction to a case manager.
Table 1 shows the percentage of child presenting problems noted in the records at case opening. Case records noted a total mean of 3.06 (SD = 1.01) presenting problems at the time cases are opened.

Family Characteristics

Information pertaining to the child's mother was found in 90% (45) of the case records. The mean age for the child's mother was 37.35 years (SD: 5.91, Range: 29-50). Fifty-eight percent (29) of the case records noted information about the child's father, with the mean age for fathers 40.21 years (SD: 6.23, Range: 29-49 years). The mean number of siblings (birth and step siblings combined) per family was 2.15 (SD: 5.68, Range: 0-16). Family problems were noted in all fifty of the case records (see Table 2), with a mean number of 2.42 family problems recorded (SD: .91, Range: 1-4).

Ninety-two percent (46) of the case records made mention of family strengths with the predominant strength noted as the family is "interested and supportive," followed by "mother is a strong advocate for the child" (32%, n=16), the extended family is supportive (22%, n=11), and characteristics of the child such as talented, gifted or insightful (20%, n=10). The mean total number of family strengths noted in the records was 1.39 (SD: .58; Range: 1-3). Only 48% (24) of the records mentioned the child and family's vision and/or aspirations for the future. Common visions for the future included the child "living a normal life" (46%, n=23), the child getting a good education or vocational training (36%, n=18), and the child getting along well with others (24%, n=12), .

Service Characteristics
The majority of families received out-patient mental health services (68%, n=34), and one-third of the families (15) received school related services. At the time of referral for case management services, the referral sources recommended the need for family support services in 74% (37) of the case records, followed by case management/coordination (64%, n=32). There continues to be a gap between services requested at the time of the Individualized Service Plan (ISP), and services obtained (at the time of the case record review). For example, as Table 3 indicates, 78% (39) of the ISP's recommended mental health services for the child with 54% (27) of these services actually obtained at the time of case record review. Educational services was another frequent item on the ISP (70%,n=35), with 50% (25) of families obtaining educational services at the time of case record review.

The most frequently cited barrier to services and resources was the "lack of specific services" (38%, n=19). Other barriers to services cited in case records included problems arising from the child's behavior (38%, n=19; e.g. the difficulty in finding a therapeutic foster home for a child who sexually acts out0, inter-agency issues (16%, n=8), funding problems (12%, n=6), problems arising from family issues (12%, n=6), and cultural issues (4%, n=2).

Child Placement History
Table 4 provides details regarding the child placement history for the 50 case records reviewed. Children receiving case management services have had a multitude of placements, with 88% (44) of the children having at least one in-patient psychiatric admission. Some of the children have been in as many as 60 foster placements over a 5 year period (see Table 5).

Child Case Manager: Contact Hours
Case managers spend the bulk of their time in contact with families and children, followed by contact with community services (e.g., school, out-patient community mental health) and residential settings (see Table 6). Case managers spend a lot of their time on the phone.

Analysis of the relationship between the amount of time case managers spend in contact with parents, children and other service providers, and the characteristics of children and families receiving children case management services revealed the following results. First, child case managers have the largest amount of total contact hours per family when the child has a history of placement in therapeutic foster care, and the least amount of total contact hours when the child has a history of a correction's placement. Second, Pearson R correlation coefficients were calculated for the frequency of the total child case manager contact hours by the child's score on the functional assessment inventory, the number of previous out-of-home placements, the total number of months in out-of-home placement, and the number of months from initial placement to most recent out-of-home placement. A moderate positive correlation was found between the total case manager contact hours and the child's score on the functional assessment inventory (R=.31, p=.029). All other child variables were found to have a minimum non-significant positive correlation.

Gender Differences

Analysis of gender differences between boys and girls with SED were calculated for child, family. and case manager variables (see Table 7). Mean scores on three variables were found to significantly differ between boys and girls. First, as noted in case records, boys, as compared to girls, had a higher number of family problems mentioned. Case managers spent more total contact time and total phone contact with families of boys, as compared to families of girls.

Return to Top

Summary

Providing community-based child case management services is a labor intensive program with tremendous variability in the amount of time case managers must devote to helping families. While case managers spend an average of 2.5 hours per week in contact with a family (by phone, in person, and in community meetings), in some situations, case managers can spend as much as 20 hours per week helping just ONE family of a child with severe emotional and behavioral difficulties.

The children and adolescents served by intensive child case management services are experiencing severe behavioral and emotional difficulties, and have experienced multiple placements and substantial time in placements. For example, children with a history of psychiatric hospitalizations had experienced, on average, 3 different placements with some children experiencing as many as 9 different placements over a 3 year period. The situation for children with a history of foster care placement is of even more concern. These children have experienced, on average 7 different placements over a 2 year period, with the outer range exemplified by one child who experienced 56 different placements over a 5 year period. Not surprisingly, as the total number of functional impairments exhibited by children increases, so does the total number of contact hours by the case manager. In other words, the more severe the child's behavior, the more time the case manager will spend with the child and family.

Case managers are spending the bulk of their time with families, children and community-based service providers: the people for whom this program was expected to assist. Families, children and school ranked highest for use of case managers' time. Case managers work with families of boys more often than families of girls, and likewise spend more time with boys than with girls. More family problems are noted in the records of boys than of girls, with case managers spending 50% more time in phone contact with boys' families. Case managers spend substantial time providing services to consent decree class members. Class members, who are not in the custody of DHS, receive the largest amount of in-person, direct contact with case managers. Case managers also spend the largest amount of time in meetings related to class members. For class members who are in the custody of DHS, the situation is different: case managers spend the least amount of their time with this group of adolescents.

Case managers work hard to return children, who have been psychiatrically hospitalized, to their communities. Children who are hospitalized while receiving case management services receive the highest number of total contact hours with the case manager: on average over 100 hours of service over a six month period. One of the major aims of the child case management program has been to assist families in creating an Individualized Service Plan (ISP) for their child. We are doing a fair job of meeting families' needs: a comparison of ISP services requested as compared to services received indicates that families receive the requested services 72% of the time, leaving families with unmet needs 28% of the time, particularly in the area of respite care.

Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

Table 1

Return to Article

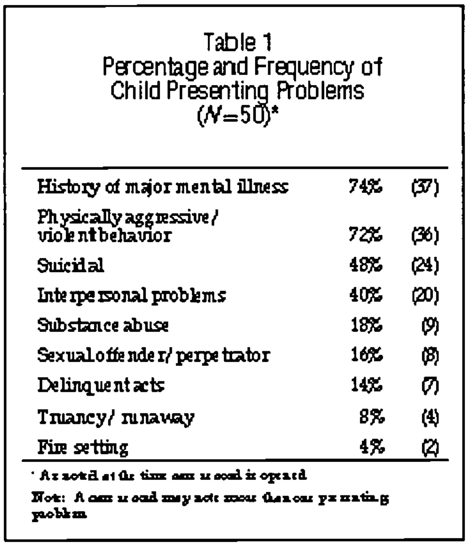

Table 1
Percentage and Frequency of
Child Presenting Problems
(*N*=50)*

History of major mental illness	74%	(37)
Physically aggressive/ violent behavior	72%	(36)
Suicidal	48%	(24)
Interpersonal problems	40%	(20)
Substance abuse	18%	(9)
Sexual offender/ perpetrator	16%	(8)
Delinquent acts	14%	(7)
Truancy/ runaway	8%	(4)
Fire setting	4%	(2)

* As noted at the time case record is opened

Note: A case record may note more than one presenting problem

[Home] [Search] [Index]

Table 2

Return to Article

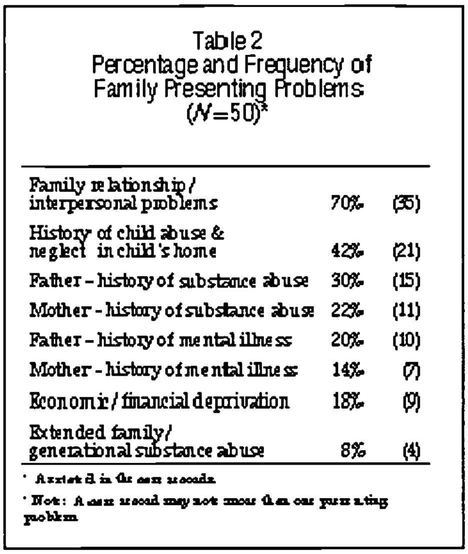

Table 2
Percentage and Frequency of
Family Presenting Problems
(*N*=50)*

Family relationship/ interpersonal problems	70%	(35)
History of child abuse & neglect in child's home	42%	(21)
Father - history of substance abuse	30%	(15)
Mother - history of substance abuse	22%	(11)
Father - history of mental illness	20%	(10)
Mother - history of mental illness	14%	(7)
Economic/financial deprivation	18%	(9)
Extended family/ generational substance abuse	8%	(4)

* [illegible] in the case records.

* Note: A case record may note more than one presenting problem

[Home] [Search] [Index]

Table 3

Return to Article

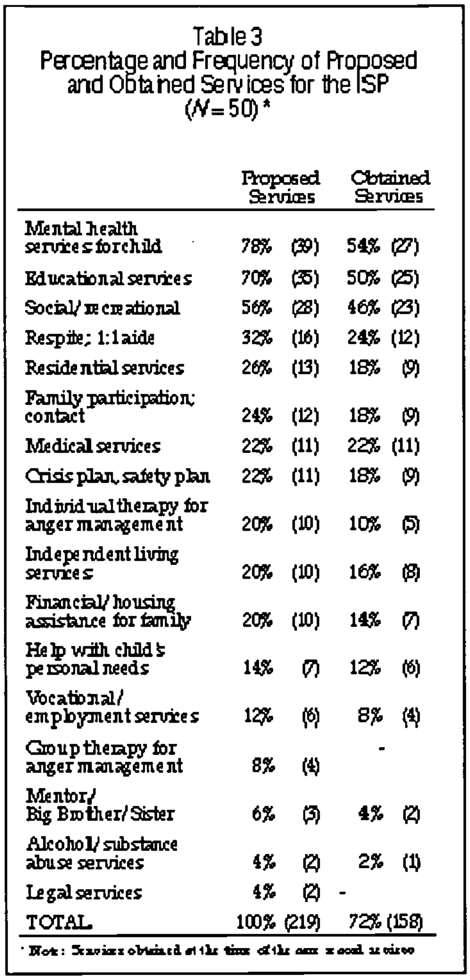

Table 3
Percentage and Frequency of Proposed and Obtained Services for the ISP
(*N* = 50)*

	Proposed Services		Obtained Services	
Mental health services for child	78%	(39)	54%	(27)
Educational services	70%	(35)	50%	(25)
Social/recreational	56%	(28)	46%	(23)
Respite; 1:1 aide	32%	(16)	24%	(12)
Residential services	26%	(13)	18%	(9)
Family participation; contact	24%	(12)	18%	(9)
Medical services	22%	(11)	22%	(11)
Crisis plan, safety plan	22%	(11)	18%	(9)
Individual therapy for anger management	20%	(10)	10%	(5)
Independent living services	20%	(10)	16%	(8)
Financial/housing assistance for family	20%	(10)	14%	(7)
Help with child's personal needs	14%	(7)	12%	(6)
Vocational/employment services	12%	(6)	8%	(4)
Group therapy for anger management	8%	(4)	-	
Mentor/Big Brother/Sister	6%	(3)	4%	(2)
Alcohol/substance abuse services	4%	(2)	2%	(1)
Legal services	4%	(2)	-	
TOTAL	100%	(219)	72%	(158)

* Note: Services obtained at the time of the case record review

Table 4

Return to Article

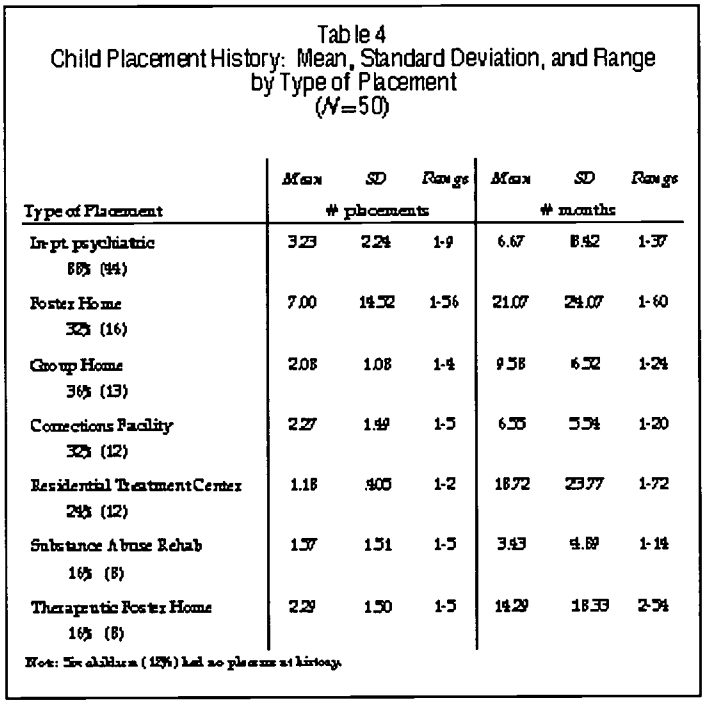

Table 4

Child Placement History: Mean, Standard Deviation, and Range by Type of Placement

(*N*=50)

Type of Placement	Mean	SD	Range	Mean	SD	Range
	# placements			# months		
In-pt psychiatric 88% (44)	3.23	2.24	1-9	6.67	8.42	1-37
Foster Home 32% (16)	7.00	14.32	1-56	21.07	24.07	1-60
Group Home 36% (13)	2.08	1.08	1-4	9.58	6.32	1-24
Corrections Facility 32% (12)	2.27	1.49	1-5	6.55	5.54	1-20
Residential Treatment Center 24% (12)	1.18	.405	1-2	18.72	23.77	1-72
Substance Abuse Rehab 16% (8)	1.37	1.51	1-5	3.43	4.89	1-14
Therapeutic Foster Home 16% (8)	2.29	1.50	1-5	14.29	18.33	2-54

Note: Six children (12%) had no placement history.

[Home] [Search] [Index]

Table 5

Return to Article

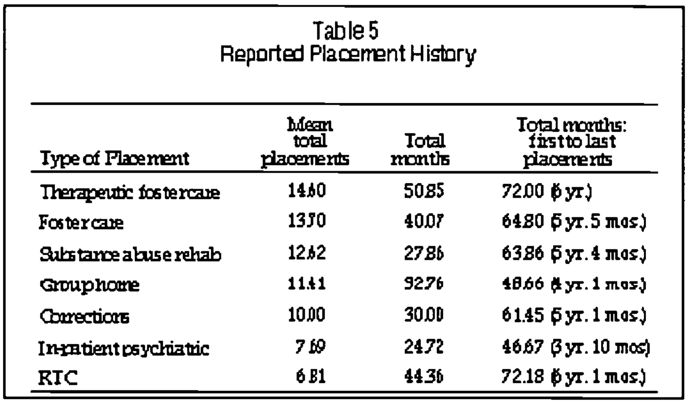

Table 5
Reported Placement History

Type of Placement	Mean total placements	Total months	Total months: first to last placements
Therapeutic foster care	14.60	50.85	72.00 (6 yr.)
Foster care	13.70	40.07	64.80 (5 yr. 5 mos.)
Substance abuse rehab	12.62	27.86	63.86 (5 yr. 4 mos.)
Group home	11.41	32.76	48.66 (4 yr. 1 mos.)
Corrections	10.00	30.00	61.45 (5 yr. 1 mos.)
In-patient psychiatric	7.69	24.72	46.67 (3 yr. 10 mos)
RTC	6.81	44.36	72.18 (6 yr. 1 mos.)

Table 6

Return to Article

Table 6
Case Manager Contact Time *

	Contact Hours		
	Mean	SD	Range
Family	2.73	2.70	0-13
Identified Child	1.07	2.10	0-13
Schools	.68	98	0-6
Out-patient MH	.66	1.38	0-9
Foster care	.45	1.60	0-11
BCSN	.41	86	0-6
DHS	28	58	0-3
Group home	26	.69	0-4
In-patient MH	24	57	0-3
Crisis services	.19	37	0-2
Corrections	.18	35	0-1
RTC	.18	36	0-2
Medical	.14	.41	0-3
Substance abuse	.03	.12	0-1
Phone time	3.56	7.22	1-50
Direct contact	2.59	2.33	1-10
Meetings	2.27	2.72	0-12
Total	8.53	10.65	1-74

* averaged by length of time case is open

[Home] [Search] [Index]

Table 7

Return to Aritcle

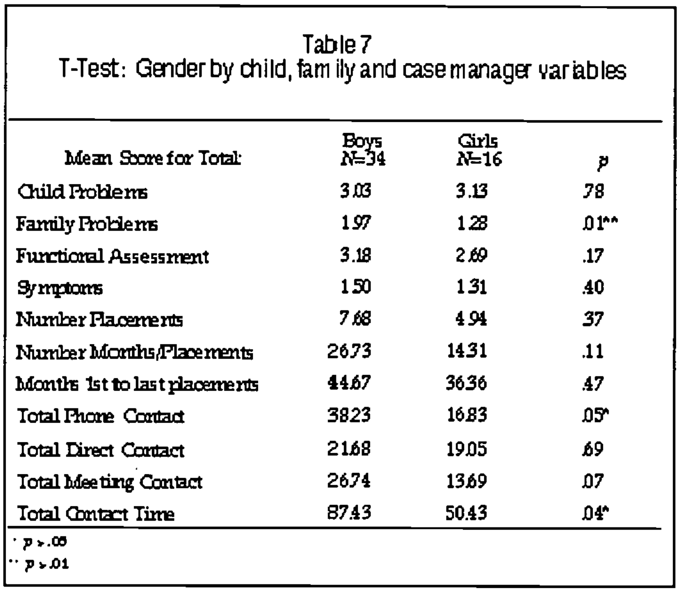

Table 7
T-Test: Gender by child, family and case manager variables

Mean Score for Total:	Boys N=34	Girls N=16	p
Child Problems	3.03	3.13	.78
Family Problems	1.97	1.28	.01**
Functional Assessment	3.18	2.69	.17
Symptoms	1.50	1.31	.40
Number Placements	7.68	4.94	.37
Number Months/Placements	26.73	14.31	.11
Months 1st to last placements	44.67	36.36	.47
Total Phone Contact	38.23	16.83	.05*
Total Direct Contact	21.68	19.05	.69
Total Meeting Contact	26.74	13.69	.07
Total Contact Time	87.43	50.43	.04*

* $p > .05$
** $p > .01$

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies,
Florida Mental Health Institute, University of South Florida,1996

Outcome-Oriented Case Planning in Child and Family Services

Authors

Introduction Methods Results References
Return to Table of Contents

Overview

Child welfare agencies across the United States, Canada, Great Britain, Wales and elsewhere are working to better define the service delivery outcomes they are striving toward (e.g., American Humane Association, 1993; Rapp & Poertner, 1987; Parker, Ward, Jackson, Wedge & Aldgate, 1991). Outcome-oriented case planning is not new to child and family services or mental health, but recently, agencies have begun to develop ways to implement this approach more thoroughly in practice.

To be most successful, the emphasis upon achieving specific outcomes must be present and supported throughout the provider organization, including line staff, supervisors, and managers. The process begins by determining how staff members assess children and families, set case goals, and develop service plans to meet those goals. Casework recording forms are critical to supporting a particular approach to service delivery planning and implementation (McDevitt, 1994).

The Importance of Goal-Setting

The human services literature has emphasized the importance of formulating clear and behaviorally specific treatment goals for many years. Research findings attest to the value of the social worker and client establishing agreed upon goals that will frame and guide their change-oriented relationship towards the desired outcomes.

Goals specify what clients wish to accomplish (Cormier & Cormier, 1991). Inherent in goals are desired outcomes or changes in life situations that correspond to particular problems that have been identified through a focused assessment process. In long-term family foster care, the client is a youth who is being cared for by someone other than immediate biological parents. Setting goals for short and longer range outcomes is often a teamed effort between the foster parent, youth and the agency social worker.

The establishment of behaviorally clear goals serves the following valuable functions for the youth, foster parents and social worker:

- Promotes agreement among the youth, foster parents and social worker regarding the immediate and long range outcomes to be achieved, thus increasing the motivation of youth, foster parents and agency staff;
- Specifies desired behavior changes more clearly, thus providing direction and continuity to helping efforts;
- Facilitates the development and selection of appropriate treatment and intervention strategies;
- Assists the youth, foster parents and social worker to monitor their progress towards the desired long range outcomes, so that each will know when and where achievements have been made, and where effort needs to be focused;

- Indicates the difference between what and how much a particular youth is able to accomplish, developmentally, in the near future and the distant future;
- Permits agency staff members to determine if they have the skills, competencies, interest and time for working with the youth or whether there needs to be a referral of the youth to someone else for best service; and
- Serves as outcome criteria in evaluating the effectiveness of specific interventions and of the overall helping process.

Employing goal-setting to achieve the above functions requires knowledge about types of goals and skills in goal negotiation on the part of the line social worker. These are some of the core competencies necessary for implementing an outcome-oriented approach to practice.

Return to Top

Defining Long-Range Outcomes

Accountability is a special responsibility for any program that sees its mission to be the "raising" of a child to adulthood. In programs geared to the provision of short-term services, for example, a concentration on short-term service goals may be appropriate. In a program that takes on a long-term parental responsibility for a child's development and future success, such a concentration is not adequate. Most long-term family foster care and group care programs have a number of long-range outcomes that guide overall practice with the youth and families they serve1.

The primary outcome is helping youth to lead successful, independent lives by developing physically, emotionally, cognitively, socially and in other ways. For example, because The Casey Family Program (Casey) delivers long-term family foster care, its long-range outcomes are concerned with safe emancipation of youth; these outcomes are collectively are referred to as the Program Vision for Children. One or more of these long-range outcomes will be used to develop a Vision for a Particular Child which is constructed individually for each child in the care of the program.

In planning for a youth, case outcomes are the expected end states or developmental milestones to be achieved. A vision for a child includes the quality, or characteristics, of eventual adulthood seen as appropriate for that youth. The term case goal is used to designate the types of outcomes that generally may take a year to two years to accomplish.

Case indicators are the more immediate changes or improvements expected to occur as a result of some action or service using a 1-6 month time frame. Indicators can also be thought of as the smaller milestones on the path towards accomplishment of case goals. The term indicator here is used in the more specific manner adopted by many other human service programs which have implemented the mission&shyp; goal&shyp; objectives/indicators paradigm.

Components of Case Planning

There are at least three major components that pertain to professional case planning in long-term foster care agencies. Some of these components are assumed and not explicitly described in program training manuals or operating guidelines:
I. Assessments
A. Child and family intake assessment; and
B. Periodic case review and assessment

II. Outcomes
A. Program vision for children and families
B. Vision for a particular child and family;
C. Case goals for a particular child and family that are outcome-oriented; and
D. Indicators that mark the progress made towards case goals;

III. Methods
A. Development of the service plan (including case resources and case methods); and
B. Services provision

Return to Top

Conclusion

This summary describes the role of case goals and indicators within the larger case planning framework in family foster care, and these goals' relationship to assessment and services provision. As we move toward greater reliance on managed care structures for providing health, behavioral health, and even general child welfare services, we must continue to stress outcomes that are practice driven. If we don't, we will face systems that are driven by costs alone, without a basis for ensuring that we will take quality and program outcomes into account.

Return to Top

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Return to Top

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Return to Top

1 The Casey Family Program is a privately endowed operating foundation, established in 1966 by Jim Casey, a founder of United Parcel Service. The Program provides planned long-term family foster care to children for whom adoption and family reunification are not probable alternatives. After child admission to the Program, family reunification or adoption permanency planning services are provided in response to a child and family's needs. Headquartered in Seattle, The Casey Family Program currently serves over 1,300 children in 23 communities in thirteen states.

Return to Article

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Systems Outcomes from Case Management for Children with Serious Emotional Disturbance

Authors

Introduction Methods Results Discussion References
Return to Table of Contents

System Level Outcomes

Having examined the major outcomes of intensive case management (ICM) for children and their families in New York State, we investigated the major outcomes at the systems level. We believe there are four major positive outcomes at this level: (1) a decrease in state-operated hospital bed use, (2) cost savings, (3) the development of additional research projects, and (4) the refinement of the ICM program.

Hospital Utilization

Being dependent on a one-group evaluation design, we used several statistical techniques to control for non-program variables that could explain the outcomes of ICM. One of these techniques is regression discontinuity analysis (Trochim, 1984). This technique was used to examine the state hospital utilization patterns of 917 children enrolled in ICM who had experienced state inpatient stays. We examined their hospital use for two years before their enrollment in ICM and two years following their enrollment. In Figure 1, the lines plot the average number of days used by children at risk of hospitalization during each time period. The analysis shows a decrease from more than 10 days (at 2 to 4 months before admission) to about 2 days per month in the post-enrollment period. This represents a significant change (-8.2 days; $p<.001$).

Regression discontinuity analysis, although one of the best types of analysis for single group designs, is open to criticism. Extreme groups such as the children enrolled in ICM may experience regression toward the mean. Therefore, we developed a post-hoc comparison group of children who had been admitted to state inpatient settings, but who were not enrolled in ICM, because this program was not always available to all eligible children. Comparison children were selected who matched an ICM client on age at first admission to the psychiatric center, gender, race/ethnicity, region of residence, diagnosis and total number of inpatient admissions, and whose total number of inpatient days was closest to the ICM client's total number of days in the two year period prior to that client's enrollment in ICM. Regression discontinuity analysis was conducted on the resulting sample of 784 children (392 x 2 groups). The analysis examined 90 day intervals over a three year period of time (See Figure 2).

The analysis showed increasing inpatient use for both groups during the pre-intervention period, but this was particularly true for the ICM group (7 days/quarter for ICM and 5 days/quarter for controls). This mean utilization decreases over time for both groups to less than 1 day/quarter for ICM children and 3.5 days for controls. There is a significant difference in the slopes of the lines for the ICM group, comparing their pre- and post-enrollment periods.

Cost Savings

Regarding cost savings, the matched group analysis was used to estimate cost savings which could be realized from a decrease in hospital use by children enrolled in ICM. If the patterns of decreased utilization are annualized, children in ICM show a decline of 83% in inpatient utilization, from approximately 28 days in the year before enrollment to 5 days in the period between 2 to 3 years post-enrollment. This compares to a decline of 34% for children in the comparison group. We converted this to bed days (22,109 bed days or 60.57 beds for the ICM group compared to 15,994 bed days or 43.8 beds for controls during the year prior to ICM enrollment; see Figure 3).

For the year period beginning two years after enrollment the data for ICM was 3,759 bed days or 10.3 beds, and for the controls, 10,556 bed days or 28.9 beds. The difference in savings that is accounted for by ICM is 12, 912 bed days annually or 35.4 beds. In terms of cost savings, using the children's state inpatient Medicaid daily reimbursable rate of $809.89/day, a decline of 35.4 beds used in a year can save $10,464,588.

Research Projects

The third systems outcome was the development of federally funded research demonstration grants that involve modification of the ICM program. ICM was targeted to children, not families, and their needs. We subsequently developed a Family-Centered Intensive Case Management model (FCICM) to be more sensitive to the context in which the child is located. For further information about this model, see Evans, Armstrong, Dollard, Kuppinger, Huz & Wood (1994). A short-term case management model (CCM) for children in psychiatric crisis also was developed, and we are conducting a study to compare the child and family outcomes associated with this model as compared to two family preservation models (see Evans, Boothroyd, Armstrong, Kuppinger, & Bellair, 1995 [this volume]).

Program Refinements

In regard to the fourth systems outcome, program refinements, in New York State we are moving to develop and disseminate a best practices model of case management. We call this model Project SEED. This Project is an effort to combine the strengths of various community-based models of care including ICM and FCICM and to study its dissemination to counties with different characteristics, service systems, and populations.

In summary, we believe that there have been significant, positive outcomes for the system of care in New York State that are associated with ICM. We expect to continue our investigations of systems level outcomes as we complete evaluative research associated with FCICM, CCM and Project SEED.

Return to Top

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Return to Top

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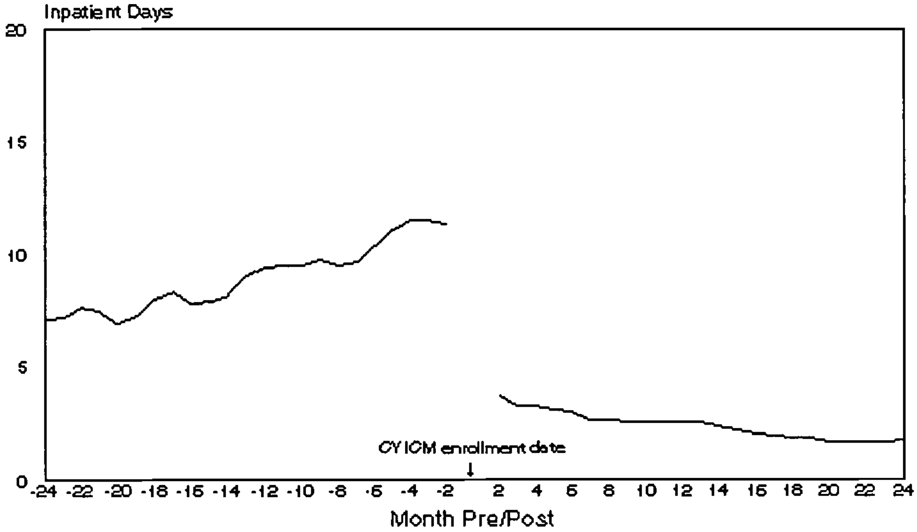
Return to Top

[Home] [Search] [Index]

Figure 1

Return to Article

Figure 1
State Inpatient Utilization
Pre/Post CYICM Enrollment
(*N*= 917)



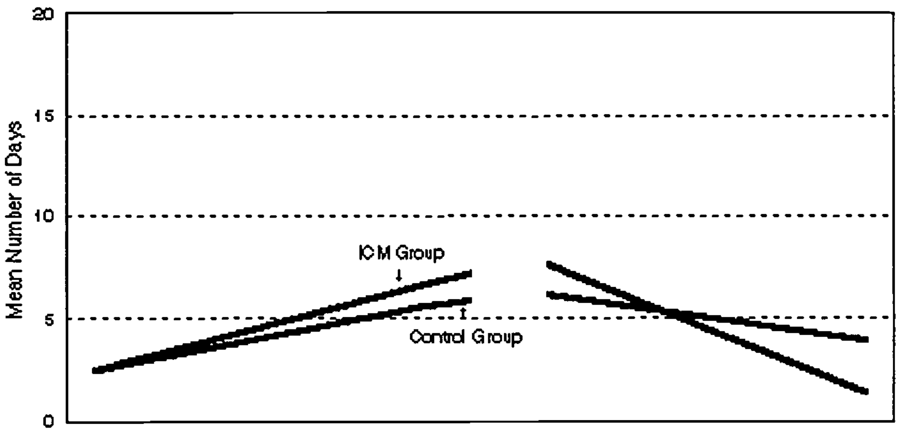
N=917

[Home] [Search] [Index]

Figure 2

Return to Article

Figure 2
Mean Inpatient Days - ICM vs. Non-ICM Comparison Group
Pre-post ICM Enrollment Comparison - 90 Day Intervals
(N = 784)

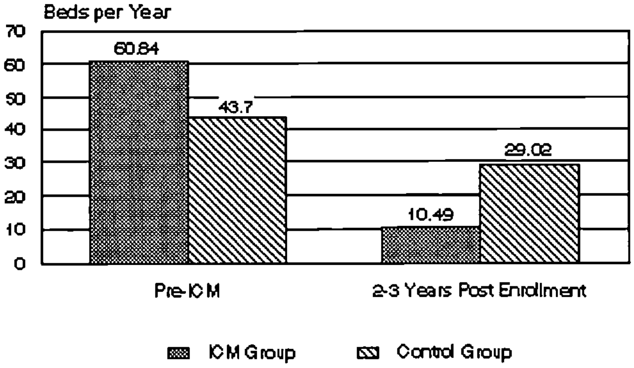


[Home] [Search] [Index]

Table 3

Return to Article

Figure 3
State Inpatient Utilization
ICM vs. Comparison Group
(n=784)



[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies,
Florida Mental Health Institute, University of South Florida,1996

Child and Family Outcomes from Intensive Case Management for Children with Serious Emotional Disturbance in New York State

Authors

Introduction Methods Results Discussion References
Return to Table of Contents

Introduction

Intensive Case Management (ICM) for children represents the cornerstone of the community-based system of care for children with serious emotional disturbance in New York State. Implemented in 1988 in various locations across the state, ICM combined high levels of service intensity with elements of individualized care to provide what was then considered to be a state of the art intensive, in-home, case management service for children who were at greatest risk of being removed from their homes.

More specifically, ICM provides 24 hour/7 day a week response capability. The program established a small caseload, 10 children per case manager, to encourage more intensive service provision. Intensive case managers conduct comprehensive assessment of child and family service needs and link to needed services. Flexible service dollars are available to meet either individual child and family needs or identified needs of the collective caseload that are not otherwise available in the local system of care.

The ICM model is an activist model which stresses the need for service delivery in non-office based settings, often in the homes of children and families. The model also promotes an advocacy role for case managers for the overall system and for children and families served.

Implementation of ICM has occurred in stages, beginning in 1988 with an initial group of 64 intensive case managers with a capacity to serve 640 children, who were spread across 34 counties in all five geographic regions of New York State. Since then the program has grown to 185 intensive case managers operating in all but a handful of counties.

Return to Top

Methods

To assess the nature of, and outcomes associated with ICM, the Bureau of Evaluation and Services Research at the New York State Office of Mental Health (NYSOMH) used three complimentary evaluation and data collection strategies.

The first and most comprehensive is the collection of a minimum data set of descriptive data items on all children who are enrolled in the program. These data are completed by intensive case managers at intake and discharge. They enable the agency to understand the population served through collection of general demographic information about children, their treatment history prior to enrollment, and measures of their education, general functioning and behavioral status when they are enrolled. Data collected at discharge allow for the availability of proximal outcome assessments such as lengths of stay, discharge disposition and shifts in living situation between enrollment and discharge.

To assess outcome in greater detail, the second strategy initiated a longitudinal study of a 30% sample of children enrolled in ICM in 1990 was randomly drawn from the minimum data set database. Data from this sample of 199 children were collected to determine the child's status at enrollment, after 6 months, and at discharge or three years, which ever came first. This study assessed the impact of the ICM program on addressing areas of unmet service needs, child functioning and provider-perceived family strengths and family functioning. Data presented from this aspect of our evaluation will focus on comparisons between baseline and the final data collection.

The third evaluation strategy employs a matching strategy between the minimum data set and other secondary data bases available from the NYSOMH to assess patterns of inpatient service utilization by children receiving ICM services and matched comparison groups.

Return to Top

Results

Table 1 presents data derived from the minimum data set on all children enrolled in ICM. To date, data have been collected on 2688 children served since early 1989. On average, ICM children are 12 years old. They are typically White and non-Hispanic, mostly male (67%), and live in a single parent household in the custody of a natural parent (75%). The typical child enrolled in ICM is educated in a special education setting (57%) and has a disruptive behavior disorder (45%). On average, ICM children have been out-of-home (either hospitalized or placed in a residential setting) two times, they have functional impairments in an average of 2.5 areas out of 5 assessed, and display an average of 5.7 problem behaviors (out of a list of 25 areas assessed).

Data on 1267 children who have been discharged shows that, on average, their length of stay is about 13.5 months with a wide standard deviation. Comparative data on the living situation of children at enrollment and discharge tell us that 81% of the 710 children who lived in those settings at enrollment are there at discharge as well.

Data from the longitudinal study which followed a sample of children through their ICM experience provide further insight into outcomes of ICM for children served. At the final data collection point, the study lost 37 cases for an attrition rate of 19% and a final sample size of 162. A logistic regression analysis predicting membership in the sample from the general population yielded no significant differences on any characteristic for which data were available, suggesting that biases introduced into the sample by attrition did not invalidate our findings.

In addition to the minimum data set, data came from two other sources: the Baseline Data Collection Form, completed by intensive case managers, which supplemented the data routinely collected at intake; and a Follow-up form, which was completed by providers at either discharge or three years following intake. These data collection points included administration of the Child and Adolescent Functional Assessment Scales (CAFAS; Hodges, 1990) as a measure of child and family functioning on six dimensions, and selected scales from among the extensive set of Child Well-Being Scales (Magura & Moses, 1986) as measures of family functioning. A measure of child behavior status, the Child Behavior Checklist (CBCL; Achenbach, 1991) was also administered to parents as part of the study.

The evaluation assessed changes in the level of unmet needs of ICM children in five life domains. Between baseline and discharge, unmet recreation ($p<.01$), medical ($p<.05$) and education ($p<.05$) needs declined significantly. Unmet mental health needs declined as well but not significantly. Unmet needs in the area of social supports remained unchanged.

The study elicited perceptions of the child's symptoms and behaviors at baseline and again at discharge. A factor analysis of 25 symptoms/behaviors that were assessed resulted in the 7 factor groupings. In the areas of aggressive behavior (physically aggressive, verbally aggressive, destruction of property, temper tantrums, dangerous to others), suicidal behavior (dangerous to self, suicidal ideation, suicide attempt), anxiety (anxiety, depression, phobias, sleep disorders),
fire setting/cruelty to animals, and psychotic symptomatology, declines were significant ($p <. 01$). Areas

of functional impairment as measured by the CAFAS show positive change in all areas with behavior towards self and others significantly improved ($p < .05$). Data from the parent completed CBCL show movement in a positive direction. On the total problem score the sample mean moved out of the clinical range between intake and discharge.

Supplemental data collected on the sample provided some greater insight into the nature of the families of which ICM children are part. Families are characterized by high incidence of unstable relations between adult members, mental illness, poverty, adults who were themselves abused as children, chronic unemployment, alcohol/substance abuse, and domestic violence (see Table 2).

Providers were also asked to assess family strengths which they felt could be built on to benefit the children. Measures of these factors showed great stability between the two data collection points with only significant ($p < .05$) change in greater recognition of families' ability to make their child feel loved and lesser ability to provide structure.

Data on impact of ICM on families of children served showed no real change. The two CAFAS family resource scales&shyp;Basic Family Needs and Family Social Supports&shyp;show no change between baseline and discharge, although mean scores on both (especially basic needs) showed low levels of problems in these areas. The Child Well-Being Scale scores used to measure shifts in family functioning also show little change between baseline and discharge. Only family's ability to recognize their child's problems improves significantly ($p < .05$).

To examine length of stay (LOS) in ICM an ordinary least squares regression analytic model was used to assess our ability to account for variation. The strongest model had an R square of about .2. Variables that significantly contributed to the model are presence of abuse in family history ($p < .05$), the number of areas of functional impairment reported on a child ($p < .05$), level of family cooperation with service provision ($p < .05$) and, the strongest contributor, geographic region. In New York City after 1.5 years, about 90% of children are still enrolled in ICM. In other regions for a comparable amount of time, 50% or fewer remain enrolled. In Figure 1, a survival analysis displays this phenomena.

To examine our ability to predict discharge disposition, we used a logistic regression approach including a dichotomized dependent variable&shyp;successful/unsuccessful termination. The sample for this analysis is reduced to 63 because about 110 of the 162 children were discharged at the final time point and there was some difficulty in accurately determining disposition in some cases. Among the 63, there is almost an exact split between successful and not.

The model successfully classified 87% of cases. Variables significantly contributing to the predictive power of the variable were change in strength of the family relationship which reduces probability of successful discharge by 63% to only 29%. Table 3 presents the findings from this analysis.

Return to Top

Conclusions

To summarize, findings from ICM evaluation activities suggest that, overall, ICM is having a positive impact on the children it serves. Data on child-specific outcomes show improvement after enrollment in ICM. Children identified as particularly needy are remaining in least restrictive, family settings. These positive outcomes are however tempered by findings suggesting that ICM has little impact on family-level outcomes. The importance of the strength of family relationship in predicting successful discharge and other data that show that case managers do spend much time working with families suggest that there may be a need to provide case managers with better tools to address family issues. The strength of regional variation in accounting for LOS variation suggest the need to investigate program differences and to examine the impact of ICM on the systems within which it operates.

Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

Table 1

Return to Article

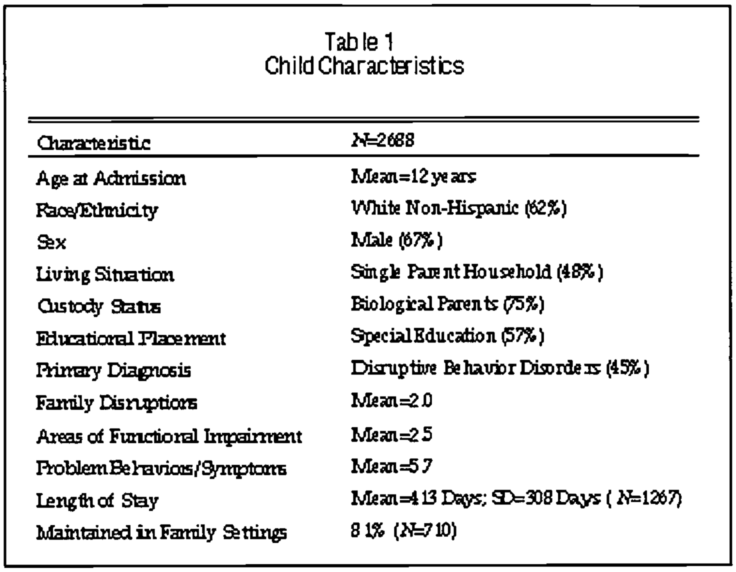


Table 1
Child Characteristics

Characteristic	*N*=2688
Age at Admission	Mean=12 years
Race/Ethnicity	White Non-Hispanic (62%)
Sex	Male (67%)
Living Situation	Single Parent Household (48%)
Custody Status	Biological Parents (75%)
Educational Placement	Special Education (57%)
Primary Diagnosis	Disruptive Behavior Disorders (45%)
Family Disruptions	Mean=2.0
Areas of Functional Impairment	Mean=2.5
Problem Behaviors/Symptoms	Mean=5.7
Length of Stay	Mean=413 Days; SD=308 Days (*N*=1267)
Maintained in Family Settings	81% (*N*=710)

[Home] [Search] [Index]

Table 2

Return to Article

Table 2
Family Conditions

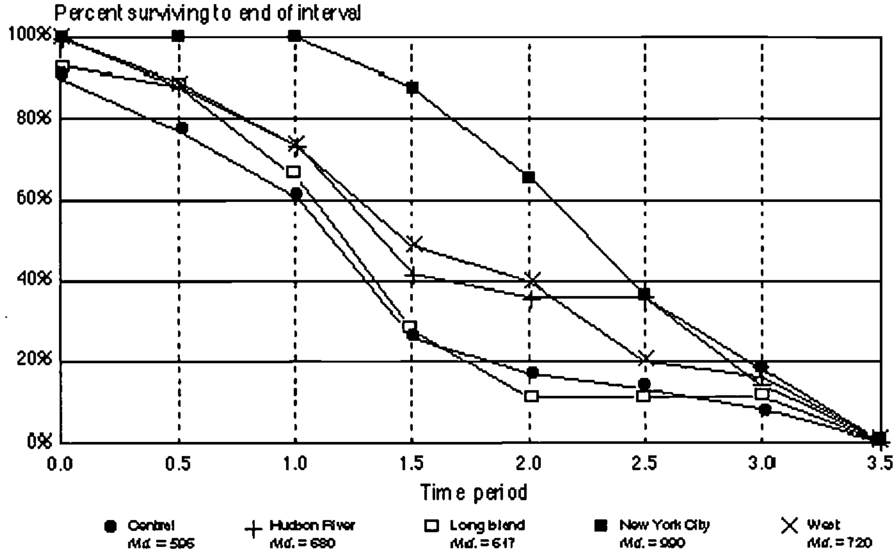
Characteristic	N=199
Unstable relationships	60%
Mental illness	56%
Poverty	53%
Adults abused as children	41%
Chronic unemployment	33%
Alcohol/Substance Abuse	30%
Domestic violence	27%

[Home] [Search] [Index]

Figure 1

Return to Article

Figure 1
Survival Analysis of Length of Stay for Each Region
(N = 106)*



*discharged children
Lee-Desu = 16.78, 4 df ($p < .01$)

[Home] [Search] [Index]

Table 3

Return to Article

Table 3
Post-Intensive Case Management
Discharge Disposition
(*N*=63)

Measure	Probability of Successful Discharge	Difference	High Model Probability of Successful Discharge
Change in Strength of Family Relationship*	0.29 (Decrease)	0.63	0.93 (Strengthening)
Change in Child CAFAS*	0.46 (Decrease)	0.47	0.93 (Improvement)
Change in Symptoms Index*	0.52 (Decline of 2)	0.41	0.93 (No change)
Age at Enrollment*	0.59 (15 Years Old)	0.34	0.93 (11 Years old)

* $p<.05$ Model correctly classifies 87% of cases

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies,
Florida Mental Health Institute, University of South Florida,1996

Project Seed: Services Evaluation and Dissemination

Authors

Introduction Methods Discussion References
Return to Table of Contents

Introduction and Purpose

Through ongoing evaluation of statewide community-based programs (Huz, Evans & Dollard, in press; Huz, Evans, Rahn, & McNulty, 1993) and three active research demonstration projects, New York is actively engaged in children's mental health services research. It is logical that we now focus on understanding and documenting the processes through which these research programs can best inform practice and promote policy change.

Project SEED (Services Evaluation and Dissemination) is a study of the process by which researchers, policy makers and practitioners disseminate recent research findings and innovative practice related to the provision of intensive case management services to children and youth with serious emotional disturbance.

The specific goals of Project SEED are: (1) to summarize the outcomes and implementation experience of Project FIRST, the Children and Youth Intensive Case Management (CYICM) program and New York's efforts to operationalize Individualized Care principles; (2) to work in collaboration with service providers and parents to integrate these findings and design an enhanced model of CYICM; (3) to develop dissemination site selection criteria; (4) to implement the enhanced CYICM model in three sites, and (5) to describe the process of dissemination, the extent to which the components of the new model were implemented, and generalize about important factors in the dissemination process.

Models for transferring knowledge derived from behavioral science research to practitioners have not been well developed (Lorsch, 1979; Astley & Zammuto, 1992). Consistent with this theme, policy makers and practitioners of children's mental health services consistently underscore the importance of research as a vehicle for modifying the system of care model and its component services (Rivera & Kutash, 1994; Stroul & Friedman, 1994; Weisz, Weiss, & Donenberg, 1992; Burns & Friedman, 1990). Recently there has been an increasing focus on services research and these studies are beginning to yield findings that can inform practice (Rivera & Kutash, 1994; Hoagwood & Hohmann, 1993). Our understanding of and commitment to dissemination is critical, if widespread system change is to occur.

The CYICM program model was developed in 1988 and it is appropriate six years later to revisit this model with input from the CYICM practitioners, family members, the service provider community, researchers and policy makers. Children and Youth Intensive Case Managers carry caseloads of no more than 10 and are available 24 hours a day, 7 days a week&shyp;either directly or through a coverage system shared with other ICM's. ICM targets children and adolescents most in need through a local selection process known as rostering. Once targeted, a child is entitled to ICM for whatever length of time is needed. A critical component is the availability of flexible service dollars for meeting individual client needs. The goal of ICM is to enable the child to succeed at home, in school, and in the community. The CYICM model's effectiveness is well-documented (Huz, Evans, Rahn, & McNulty, 1993; Banks & Evans, in press; Evans, Banks, Huz, & McNulty, 1994), and the practices of the most effective CYICM programs and providers will factor prominently in the design of an enhanced CYICM model.

In 1991 funding was obtained from NIMH for Project FIRST (Family-Focused Intensive Resources for Services and Treatment, NIMH R18MH5035/CMHS 5HD5SM50357). The project provided resources to compare child, family, and system outcomes for children referred and accepted for therapeutic foster care who are randomly assigned to either therapeutic foster care or Family-Centered Intensive Case Management (FCICM). FCICM, itself a modification of the original CYICM program model, has been successful in keeping children at home who would otherwise have been placed in a therapeutic foster home or other more restrictive placement (Evans, Armstrong, Huz, & Dollard, 1993).

In the FCICM model, CYICM caseloads were reduced, a parent advocate joined the case manager as a member of the treatment team, and additional support services such as respite care, parent support groups, parent skills training, and flexible service funding (Dollard, Evans, Lubrecht, & Schaffer, 1994) were made available (Evans, Armstrong, Dollard, Huz, Kuppinger, & Wood, in press). An extensive battery of assessments and documentation of implementation issues from Project FIRST will inform the design of the enhanced CYICM model. The experience of FCICM also suggests that CYICM resources may be adapted to effectively service a population of children at particularly high risk of placement.

Finally, the enhanced CYICM model will incorporate individualized care principles and practice. New York is committed through a number of initiatives to ensure that services focus on the individual child and family; provide services within a normalized environment; work in partnership with families; use a strengths-based, ecological orientation; demonstrate cultural competence; and be provided "unconditionally"
In addition to the potential for improved service delivery at each site, this project will advance our understanding of a number of dissemination issues: (1) dissemination techniques (2) methodologies for measuring program model fidelity and adaptation, and (3) the relative importance of site, program, and population characteristics (Bauman, Stein & Ireys, 1991; Blakely, et al., 1987; McGrew, et al., 1994).
Return to Top

Research Design and Methods

This project takes place over a four year period. Year 1 involves preliminary work necessary to develop the enhanced CYICM program model, a dissemination plan, data collection and analytic strategies. During Year 2, the enhanced CYICM program model dissemination will begin in a pilot county. During Years 3 and 4, the enhanced CYICM model will be implemented in two additional counties for intensive study of the model dissemination and implementation process. Year 1 activities are described more fully below.

Year 1: Development of the Enhanced CYICM Program Model

The first year of this study involves the accumulation of information which will result in the development of an enhanced CYICM model and a plan for dissemination. Findings from the experience of implementing the novel program components of Project FIRST's FCICM program will be documented and aggregated and contribute to an enhanced CYICM program model. Project staff will interview key FCICM participants to gather detailed information on FCICM services such as: involving a parent advocate in the delivery of service to children and families, incorporating respite resources, developing parent support groups, and providing parents with behavior management skills training.

Data on the best practices of currently operating CYICM programs will also be collected during Year 1 to assess innovative and successful program strategies. A survey instrument on program elements that have been found to be successful is now being piloted at two ICM sites. The instrument covers the following areas: admission criteria, family involvement, use of flexible service dollars, interagency collaboration, and discharge practices.

A sample of 100 CYICM supervisors and case managers from 25 CYICM provider agencies will be selected to participate in the survey. The sample will be selected on the basis of findings from the evaluation of CYICM services. Criteria for selection will include geographic diversity, a well developed discharge policy, and a successful record of maintaining the most needy of the CYICM target population in the least restrictive living situations. A sample of parents and youth will also be surveyed for feedback on their experiences with receiving CYICM services.

Data from this survey and the Project FIRST experience will be analyzed and used to guide a series of focus groups involving intensive case managers, their supervisors, and parents of children enrolled in CYICM programs. The focus groups will be the final step in the development of a feasible enhanced CYICM program model and implementation plan.

Data Collection Strategy

Measures of child, family and provider characteristics, program fidelity, and service utilization will be administered over 18 months of initial program implementation in the two research sites. A Human Resource Questionnaire (HRQ) will be administered to assess characteristics of individuals directly delivering services to children and families. The HRQ has been used extensively in many evaluations of children's mental health services in NYS (Huz, Dollard, & Evans, 1990).

The Child Description Form (CDF) and Program Termination Form (PTF) are extensively used to collect data on the demographic characteristics of children enrolled in intensive community-based and residential services in NYS. (Huz, Evans, & Dollard, 1994). These data will allow for comparison of characteristics of children served in enhanced ICM with children served in other sites.

A Program Fidelity Index (PFI) adapted from an instrument and process designed by McGrew, Bond, Dietzen and Salyers (1994) will be developed to assess the degree of implementation of enhanced CYICM program components. The PFI will be administered to parents of children receiving enhanced CYICM, the service team (ICM's, parent advocates, respite staff), and program administrators. The degree of convergence from these multiple perspectives will reinforce the reliability of the research findings.

The Program Contact Log (PCL), adapted from the Daily Contact Log developed by Brekke and Wolkon (1988), will elicit data on the degree and intensity of contact between service providers and children and families.

The Service Involvement Survey (Research and Training Center on Family Support and Children's Mental Health, 1992) will be adapted and administered to parents and children receiving enhanced ICM services at the onset of the project and at 6, 12, and 18 months to elicit data from the parent perspective on enhanced ICM implementation. Items included in this form measure the intensity of service provision and key components of individualized care and cultural competence.

Return to Top

Significance of Study

This study can feed 2 streams of more intensive services research: outcome research associated with enhanced CYICM and services research technology transfer. An assessment of the outcomes of enhanced CYICM including changes in child and family functioning, system effectiveness, and parent satisfaction could be the impetus to modify children's case management programs across the country.

Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Effectiveness of Intensive Case Management for Homeless Adolescents After Twelve Months

Authors

Introduction Methods Results Discussion References
Return to Table of Contents

Introduction

Runaway and homeless adolescents present serious challenges to service providers. They are often victims of abuse, and as such they suffer from the developmental delays and emotional problems that would be expected. Others may be afflicted with behavioral or emotional problems that have interfered with their ability to stay connected with a non-abusive family. Dealing with emotional and behavioral problems while simultaneously trying to stabilize the living situations of these adolescents&shyp;perhaps reuniting them with their families or perhaps helping them to establish independent households&shyp;is a daunting task. On the face of it, it seems likely that professionals with mental health training and ample time to deal with each case should be able to do a better job than paraprofessionals burdened with substantially larger caseloads.

We report here the results of a one-year follow up of runaway and homeless adolescents who were offered case management and mental health services at two levels of intensity.

Return to Top

Procedures

Procedures and interventions are described more fully in Cauce, Morgan, Wagner, Moore, Sy, Wurzbacher, Weeden, Tomlin & Blanchard (1994). We provide only a brief description here.

Subjects & Site

YouthCare's Orion Center, in downtown Seattle, houses a variety of services for runaway and homeless adolescents: meals, recreational programs, food and clothing banks, a school program that is part of the Seattle school systems, a health clinic affiliated with the University of Washington, and mental health services supervised by the Seattle Mental Health Institute. The subjects of the study were homeless and runaway adolescents who approached the Orion Center for services. To be eligible for study participation, the youth had to be currently homeless, not in the physical custody of law enforcement agencies, at least 13 and not yet 21 years of age, not judged to be an immediate risk to the interviewers, and willing to agree to a series of interviews over the course of one year.

Interventions

Youth approaching the Orion Center for any services are assigned to a case manager who tries to connect the youth with appropriate services. "Regular" case managers have caseloads of 18 to 30 clients, and often have other duties.

The experimental intervention consisted of a core of case managers with at least masters-level training in mental health issues, usually with an MSW degree. These case managers were provided with low case loads (maximum 12), access to psychiatric services for clients, and flexible funds for the clients' benefit (See Cauce et al., 1994, for more information). Youth agreeing to take part in the study were randomly assigned to either "services as usual" or to the "intensive" condition.

Measurements

Study participants were interviewed at three-month intervals over the course of one year. The instruments administered included the Youth Self Report (YSR; Achenbach, 1991), the Reynolds Adolescent Depression Scale (RADS; Davis, 1990; Reynolds; 1987), the Problem Behavior Scale (PBS; Mason, Cauce, Gonzales, Hiraga, & Grove, 1994), the Personal Experience Screening Questionnaire for drug and alcohol use (PESQ; Winters & Henley, 1987), the Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965, 1979), and as a measure of life satisfaction, the Life Domains Scale (LDS; Baker & Intagliata, 1982). A variety of biographical information was collected; here we report only on victimization.

Return to Top

Results

Three data points were examined on each measure for all participants with sufficient data. The baseline data points were based on the initial interview. Mid-point data were either from the six-month interview (first choice) or the three-month interview (second choice). Final data were either from the 12-month interview (first choice) or the nine-month interview (second choice). Repeated measures ANOVA with trend analysis was used on these three data points. One hundred and fifty youth were included in this analysis, 78 in the intensive condition and 72 in the regular condition.

The results are summarized in Table 1. As indicated in the "Group Differences" column, two of the ten measures (drug and alcohol use and reported victimization in the last three months) differed significantly between the groups at the start. We are unable to explain these differences as anything other than random sampling variation. The initial random assignment to conditions was rigorously adhered to. The results suggest that there were no significant differences in the ways the two groups responded to treatment, as shown in the "Group by Time" column. In nine of the ten measures, there were significant changes over time for both groups. These are shown in the "Time" column. All significant changes were improvements; nothing changed significantly for the worse.

Figure 1 shows a graph of the changes in the Youth Self Report Externalizing scale. Both groups showed improvement with time; the improvement is statistically significant, and the lines are close to parallel. The very slight differences between the groups that appear upon inspection are not statistically significant when tested. This is the typical pattern for the results in Table 1.

Return to Top

Discussion

Based on these results, we concluded that case management is effective in helping with the emotional and behavioral problems of runaway and homeless adolescents. The results do not show that specialized mental health training or artificially low case loads make a detectable difference in the overall effectiveness of these case management services. It appears that experienced paraprofessionals do as well as MSWs in this environment.

There may still be differences in the ways that individuals with different presenting problems or different background experiences respond to the different services. This possibility will be investigated in future analysis.

Return to Top

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Return to Top

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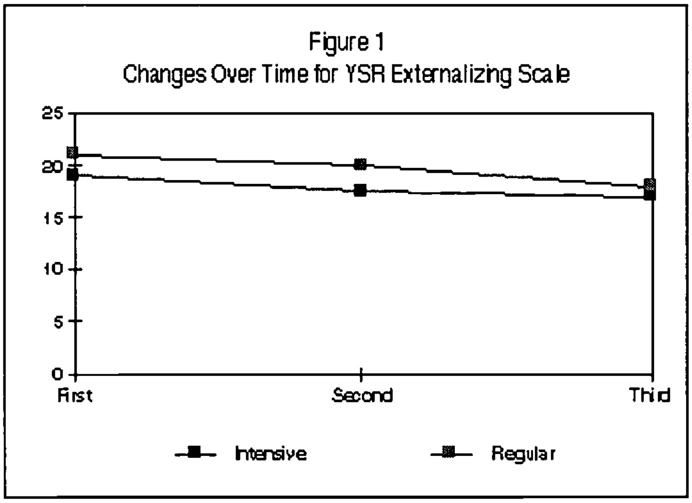
Return to Top

[Home] [Search] [Index]

Figure 1

Return to Article



[Home] [Search] [Index]

Table 1

Return to Article

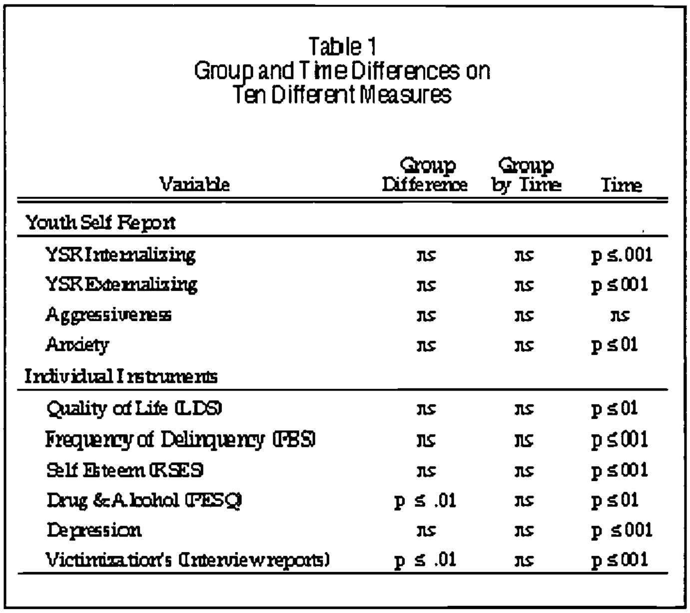


Table 1
Group and Time Differences on Ten Different Measures

Variable	Group Difference	Group by Time	Time
Youth Self Report			
YSR Internalizing	ns	ns	$p \leq .001$
YSR Externalizing	ns	ns	$p \leq .001$
Aggressiveness	ns	ns	ns
Anxiety	ns	ns	$p \leq .01$
Individual Instruments			
Quality of Life (LDS)	ns	ns	$p \leq .01$
Frequency of Delinquency (FBS)	ns	ns	$p \leq .001$
Self Esteem (RSES)	ns	ns	$p \leq .001$
Drug & Alcohol (PESQ)	$p \leq .01$	ns	$p \leq .01$
Depression	ns	ns	$p \leq .001$
Victimization's (Interview reports)	$p \leq .01$	ns	$p \leq .001$

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida, 1996

Return to Table of Contents

Symposium: Alternatives to the Hospitalization of Youth Presenting Psychiatric Crises

Scott W. Henggeler, Mary E. Evans, Albert J. Duchnowski & Barbara J. Burns

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Empirical Evaluation of an Alternative to Hospitalization for Youth Presenting Psychiatric Emergencies

Scott Henggeler, Alberto Santos, Susan Pickrel, Barbara Trout, Thomas Hiers, Joseph Zealberg, Lisa Hand & Melisa Rowland

---

An Experimental Study of the Outcomes Associated with Three Crisis Intervention Programs for Children in Psychiatric Crisis and Their Families: Preliminary Findings

Mary E. Evans, Roger A. Boothroyd, Mary I. Armstrong, Anne D Kuppinger & Paul E Bellair

---

The Alternatives to Residential Treatment Study: Initial Findings

Albert J. Duchnowski, Michael Johnson, Kimberly Hall, Krista Kutash & Robert Friedman

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Return to Symposium Menu

Symposium:
Alternatives to the Hospitalization of Youth Presenting Psychiatric Crises

Authors

Introduction

The purpose of this symposium was to describe preliminary data evaluating empirically-based alternatives to the hospitalization of youth presenting psychiatric crises. The pages that follow summarize three presentations which addressed this topic area.

The first presentation addressed the reasons for generating these alternatives, followed by a description of a recently funded NIMH R01 study developed to determine whether an intensive family- and home-based treatment utilizing multisystemic therapy (MST) is a more effective and less costly strategy than hospitalization for addressing the mental health emergencies of adolescents with severe emotional disturbances (SED).

The second presentation reported on the early outcomes of a federally-funded project in the Bronx, NY in which children presenting for psychiatric emergency services were randomly assigned to one of three treatment conditions.

The last presentation described the methodology developed for the Alternatives to Residential Treatment Study (ARTS) and reported the preliminary findings from a sample of subjects in the first wave of a project evaluating longitudinal outcomes. Finally, the policy implications of these projects were discussed.

Return to Top

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Return to Top

Return to Symposium Menu

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Empirical Evaluation of an Alternative to Hospitalization for Youth Presenting Psychiatric Emergencies

Authors

Methods References

There is a widely held concern that children's mental health services have overrelied on expensive and restrictive inpatient treatments (e.g., Burns & Friedman, 1990; Henggeler & Santos, in press; Office of Technology Assessment, 1986, 1991; Saxe, Cross, & Silverman, 1988; Sondheimer, Schoenwald, & Rowland, in press; Stroul & Friedman, 1986). Such overreliance presents several significant difficulties that have important implications for clinical practice and health policy.

First, a grossly disproportionate percentage of mental health dollars are devoted to a relatively small percentage of youth who may or may not require such intensive services (Dougherty, 1988; Burns, 1991).

Second, this disproportionate allocation of financial resources might be justified in part, if youth treated in inpatient facilities were significantly more disturbed than their counterparts who are treated in outpatient facilities. Yet, studies indicate that approximately 50% of the youth treated in inpatient facilities do not have a severe or acute mental illness and that a proportion of youth presenting danger to themselves or others do not require inpatient treatment, especially if a home-based crisis intervention is available (Weithorn, 1988).

Third, there is no evidence indicating that inpatient psychiatric treatment of adolescents is more effective than any less restrictive treatment including no treatment (Burns, Thompson, & Goldman, in press; Office of Technology Assessment, 1991; Stroul & Friedman, 1986; Tuma, 1989).

Fourth and finally, psychiatric hospitalization can have substantial negative effects. Hospitalization (a) fails to empower families, subsequently fostering dependence (Kiesler & Sibulkin, 1987; Sondheimer, Schoenwald, & Rowland, in press) (b) greatly restricts individual liberties and often pressures youth to conform to behavioral norms that have little counterpart in the outside world (Melton & Spaulding, in press); and (c) exposes youth to poor role models and labels them in ways that can impede future functioning (Henggeler, 1989).

The central goal of this NIMH funded RO1 study is to determine whether an intensive family- and home-based treatment (Crisis Family Preservation) is a more effective and less costly strategy than psychiatric hospitalization for addressing the mental health emergencies of adolescents with SED. Specifically, this study includes a 2 (treatment condition: Crisis Family Preservation vs. hospitalization) x 5 (time of assessment: within 24 hours of referral, post hospitalization, post family preservation, and 6- and 12 month follow-ups) design, with random assignment of yoked subjects to treatment conditions. Participants will include 252 12-17 year-old adolescents with SED referred to the projects by the Youth Crisis Stabilization Program of the Charleston/Dorchester Community Mental Health Center. Youths will be presenting severe mental health problems such as homicidal intent, suicidal intent, serious affective disorder or psychosis. A comprehensive multimethod, multisource evaluation will address the following questions:

1. "To what extent does Crisis Family Preservation services prevent hospitalization and reduce the symptoms precipitating the crisis?"
2. "Over the long-term (12 months), to what extent does Crisis Family Preservation maintain reductions in identified symptoms; ameliorate the family, peer and community problems

associated with such symptoms; and prevent subsequent institutional placement?"

3. "What factors moderate or mediate treatment?"
4. "What are the comparative financial costs of the treatment conditions?"

Return to Top

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Return to Top

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Return to Top

Return to Symposium Menu

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

An Experimental Study of the Outcomes Associated with Three Crisis Intervention Programs for Children In Psychiatric Crisis and Their Families: Preliminary Findings

Authors

Method Results Discussion References

Return to Symposium Menu

Crisis Intervention

Each year, approximately 55,744 children in New York State present at hospital emergency rooms experiencing a psychiatric crisis. Very little is known about the services they receive and the effectiveness of these services. The same can be said for children with acute psychiatric problems presenting nationwide. Although a number of intervention programs have been developed for these children and their families, little systematic data exist to evaluate the outcomes associated with these programs.

In 1987, the New York State Office of Mental Health established Home-Based Crisis Intervention (HBCI) programs in five sites, including the Bronx. HBCI, an intensive in-home family preservation program, is New York's version of the Homebuilder's model developed in Tacoma, Washington (Kinney, Madsen, Flemming & Haapala, 1979). This program was designed to prevent out-of-home placement, including hospitalization of children in psychiatric crisis. The federally funded research demonstration study [National Institute of Mental Health (NIMH)/Center for Mental Health Services (CMHS)] discussed here sought to answer questions regarding the effectiveness of this program in comparison with a culturally competent, enhanced program (HBCI+) and a crisis case management program (CCSI). Specifically, the questions we sought to answer were: What program works best for whom? Can these services be used instead of hospitalization? What factors are associated with service choices for children in crisis and their families?

The following table briefly outlines the salient characteristics of the three programs being studied in this research. All are intensive, in-home interventions which are typically four to six weeks in length.

Based on the logic model for this research, we are collecting data in the areas of child characteristics, family characteristics, provider characteristics, program characteristics, child outcomes, family outcomes, system outcomes, and provider outcomes.

[Home] [Search] [Index]

Table 1

Return to Article

Table 1
A Comparison of Home-Based Crisis Intervention (HBCI), Enhanced Home-Based Crisis Intervention (HBCI+), and Crisis Case Management (CCM)

Program Attribute	HBCI	HBCI+	CCM
Target population	Children and youth living at home who are at-risk of an inpatient admission due to psychiatric crisis	Children and youth living at home who are at-risk of an inpatient admission due to psychiatric crisis	Children and youth living at home who are at-risk of an inpatient admission due to psychiatric crisis
Program goals	Resolve immediate crisis, teach skills, improve family relationships, link to needed services	Similar to HBCI with the added goal of providing long-term family support services	Assess needs, provide concrete services, link child and family to needed services
Program focus	The child within the context of the family	The child within the context of the family	The child within the context of the family
Caseload per worker	Two families in crisis	Two families in crisis	Four families in crisis, four families requiring "generic" case management services[1]
Duration of service	4-6 weeks	4-6 weeks	4-6 weeks
Respite	No respite provided	In-home and out-of-home respite available	In-home and out-of-home respite available
Staff training	HBCI training	HBCI training, plus training in cultural competence and working with violence in families	Intensive case management and crisis intervention training
Post-crisis family support services	No post-crisis family support services provided	Services available through bilingual, bicultural parent advocate who establishes a parent support group and provides individual parent advocacy	No post-crisis family support services provided
Flexible service dollars	Not available	An average of $100 per family available to meet individualized needs	An average of $150 per family available to meet individualized needs
In-home visits and supports	Provided within 24 hours of intake and on a regular and frequent basis throughout the crisis period	Provided within 24 hours of intake and on a regular and frequent basis throughout the crisis period	Provided within 24 hours initially, and as needed thereafter
Psychiatric services	Psychiatrist available to provide assessment and treatment services within the home	Psychiatrist available to provide assessment and treatment services within the home	Psychiatrist consultation available to crisis case managers and to families for medication review
Funding	State resources only	State resources for HBCI components and grant funds for enhancements	State resources for case managers and in-home respite and grant funds for out-of-home respite

[1] Families receiving "generic" case management services are not part of this research project.

The services demonstration involved the establishment of HBCI+ through enhancing the basic HBCI model with respite care, flexible service money, a parent advocate, and staff training in cultural competence, as well as working with families who may be exposed to violence within the family or larger environment. The Hispanic Research Center provided the training in cultural competence, translated instruments into Spanish, pre-tested the instruments and was responsible for data collection in children's homes. Training regarding intrafamily violence was provided by Earl Braxton and colleagues and training on strategies for raising children in socially toxic environments was provided by James Garberino. Crisis Case Management (CCM) was developed from New York's Intensive Case Management program by providing staff training in dealing with children in crisis, providing respite care, and by decreasing the caseload of case managers.

Return to Top

Method

The research uses a three group positive-controlled randomized study design in which eligible, consenting children/families presenting to two of the three emergency intake sites in the Bronx are randomly assigned to one of the three treatment conditions (HBCI, HBCI+, CCM). Eligible children are those 5 to 17 years of age, living in the Bronx at home with a natural, foster, or adoptive family, who are experiencing a psychiatric crisis requiring immediate intensive intervention. In the absence of these services the child would likely be hospitalized or placed in a restrictive setting. Finally, it must be safe for the child to return home with intensive services and the family must be willing to receive in-home services. Data on the child and family characteristics and functioning are collected on intake, at termination from the intensive program (4-6 weeks), and at 6 months post-termination. Data are also collected on all children presenting to the psychiatric emergency settings to allow comparison of those hospitalized, referred to in-home services, and referred to other less intensive services in the community.

Return to Top

Results

The data presented are for the first 125 children/families enrolled in the intensive in-home interventions and the first 671 children presenting to the emergency settings. The children average 12.4 years (range 5-18) with equal proportions of males and females. The majority were of Hispanic origin (64%), with 30% Black/African-American and 6% other. The most common diagnoses were disruptive behavior disorders (30%), with 18% presenting with adjustment disorders, 14% with psychotic disorders, and 17% with mood disorders. Clinicians noted that 77% were experiencing functional impairment due to the disorder and 86% demonstrated behavior dangerous to self or others. Of these children, 51% were enrolled in special education programs, 40% had received prior mental health treatment and 9% had been previously hospitalized for a psychiatric disorder.

Most of the children (76%) were being raised in single parent households of three or more children (55%). Few mothers had completed high school (25%) and few were working (25%). Most received assistance from Medicaid (65%) and/or Aid to Families with Dependent Children (36%). More than half the families had an income less than $10,000 per year.

Figure 1 shows the overall dangerousness of the child's condition as rated by clinicians using a risk assessment instrument developed by Gutterman and Levine (1992). Significant differences in the assessed dangerousness existed among children referred to each of the three interventions.

Children admitted to the hospital were most at risk clinically, had the lowest capacity for cooperating with a treatment plan and had the lowest parental support, while those in the in-home condition were intermediate, and those referred to other community programs were rated least at risk on all three subscales.

[Home] [Search] [Index]

Figure 1

Return to Article

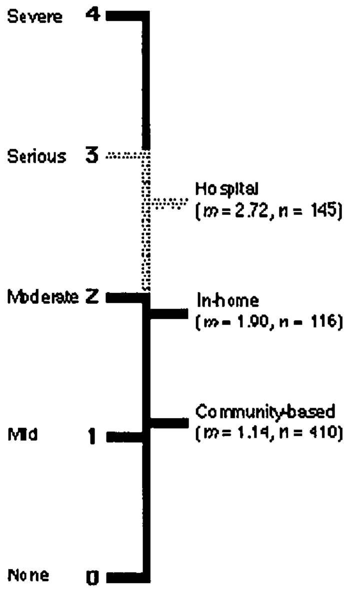

Figure 1
Overall Dangerousness of
Child's Condition
(*N*=641)*

* All group differences statistically significant.
Gutterman et al, 1993.
Bronx 2/95

Looking at data for the first 86 children to complete the in-home intervention indicates that they experienced a significant gain in self-esteem from intake (Mean = 47.4) to discharge (52.5) as measured by the Piers-Harris Children's Self-Concept Scale (Piers, 1984). Beginning with high t-scores on Total Problems, Internalizing and Externalizing subscales as measured by the Child Behavior Checklist (Achenbach, 1991), these children did not experience a decrease in their scores on discharge from the intensive programs.

Regarding family data, scores on cohesion and adaptability, as measured by the Family Adaptability and Cohesion Scales (Olsen, Portner & Lavee, 1985) increased significantly from admission to discharge (see Figure 2).

The family's social supports, measured by the Inventory of Socially Supported Behaviors (Barerra, Sandler & Ramsey, 1981) indicated no change from admission to discharge. What is most striking is that the social support scores were so low for families enrolled in all three programs, indicating that families were not only financially, but socially impoverished.

Finally, regarding parent satisfaction with the treatment program, parents in all three conditions reported a high level of satisfaction with services. It is interesting to note, however, that there was an ordered effect regarding satisfaction with skills gained. Parents in CCM were least satisfied, those in HBCI were intermediate and those in HBCI+, as we hypothesized, were most satisfied.

Return to Top

Discussion

This project is still in an early stage. We will be enrolling children/families until we have 260 families completing the intervention. To date, however, we have learned several things. The first is that children in psychiatric crises can be cared for safely in their homes, given a sufficiently intensive intervention. Secondly, left to exercise their clinical judgment, clinicians differentiate among children referred to inpatient, in-home and community treatment settings. That is, they make decisions regarding the child's placement based on their assessment of the severity of the child's condition and the child and caregiver's ability to participate in a treatment plan. The data indicates that the in-home programs may not be functioning to divert hospitalization, one of the original goals for these programs. A sizeable proportion of the children assessed (20%) are referred for hospitalization despite the availability of intensive in-home services.

Return to Top

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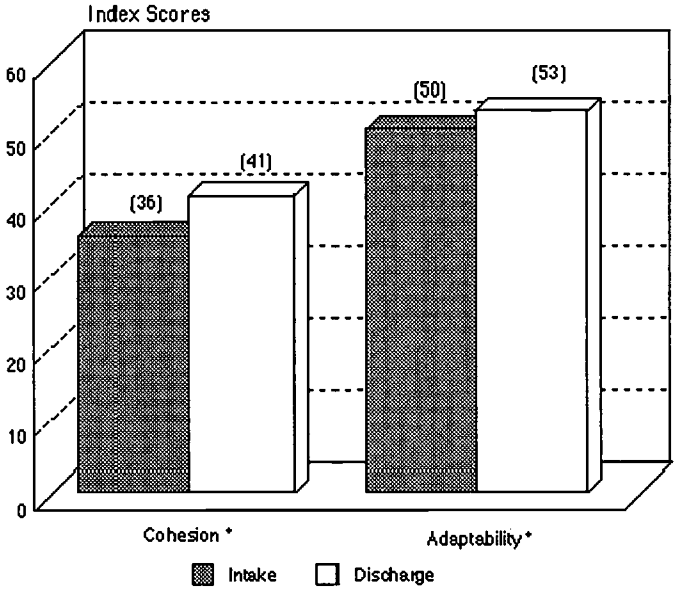
[Home] [Search] [Index]

Figure 2

Return to Article

Figure 2
Family Adaptability and Cohesion
(N=86)



* Gains from intake to discharge are statistically significant

Bronx 02/95

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Return to Top

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Return to Top

Return to Symposium Menu

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

The Alternatives to Residential Treatment Study: Initial Findings

Authors

Results References

Introduction

As the public sector becomes more and more driven by the requirement to demonstrate accountability for its policies and programs, the children's mental health system will be required to support policy decisions with favorable outcomes. As Burns and Friedman (1990) have indicated, empirical data in the children's mental health field is sparse. Furthermore, it is a new field with emerging methodologies and measurement instruments. In this context of pressing need and evolving research strategy, the Alternatives to Residential Treatment Study or ARTS was implemented.

While a randomized clinical trial would be the best approach to evaluate the efficacy of alternatives to residential treatment, we determined that available resources and currently available instruments could not adequately support such a study. Consequently, we attempted to design a systematic, descriptive study that would give important information to the field and contribute to the knowledge base. The system of care framework developed by Stroul and Friedman (1986) had a major influence on the CASSP initiative and offered a focus for ARTS.

By the early 90s the conventional wisdom about treating children with serious emotional disabilities began to shift in the location of treatment. Previously, it was assumed that intensive treatment could only be delivered in a hospital or institutional residential setting. This assumption was being challenged by an emerging collection of programs that attempted to keep the child in a community setting, preferably at home or in a home-like setting. The Kaleidoscope Program in the inner city Chicago area emerged as a leader through many training activities for the CASSP community and then through the adoption of its program principles by Alaska and Vermont for state-wide program implementation. Another important influence at the time was the Ventura County Children's Demonstration Project in California. This program served as an example of cross agency, collaboration to implement an integrated service delivery system with flexible funds and community based programs. The Therapeutic Foster Care Program offered by the Pressley Ridge Youth Development Extension (PRYDE) was another influential program in terms of its training and research activities. These programs offered a natural laboratory to examine the emerging models of family centered, child focused treatment models that were alternatives to traditional institutional placement.

The design we planned aimed to answer some important questions in the field. These questions were: What are the characteristics of the children served in these programs? What are their social service histories? What services are delivered in these programs? What happens to children in these programs over time in terms of their symptoms, cognitive and emotional functioning, and living conditions?
Return to Top

Results and Discussion

The ARTS protocol and procedure have been fully described in an earlier publication (Duchnowski, Johnson, Hall, Kutash, & Friedman, 1993). The protocol was administered at program entry, six months, and twelve months after admission. There were 144 children in the study.

These programs serve youths who have multiple problems that are of a long duration and severe in intensity. With an average age of slightly over 14, there were 61% who had contact with the justice system for an average of eight times. They had an average of four placements in mental health residential treatment centers and only 36% entered the current program from their home.

Involvement with the child welfare system was common. Sixty-nine percent of the families had worked with a child protection worker because of a charge of abuse or neglect. In addition, 55% of the children in the study had been placed out of their home because of a charge of abuse.

The group as a whole had very poor academic performance, with 80% below grade level in reading and 90% in math. Not surprisingly, 80% had a past history of placement in special education programs.

This is a group of youngsters that was well known to the major child serving agencies, i.e., mental health, child welfare, juvenile justice, and special education upon placement in the programs that we studied. The average age of problem onset was reported to be 6.8 years while the average age at the time of first service was 8.7 years. On the average, almost five more years would elapse before the children were placed in the current program, a time during which there were multiple contacts with multiple agencies.

There was an unexpectedly low number (36%) of children who were living with their family at the time of program entry. Since all of these programs valued family preservation, we anticipated that we would observe extensive work with families. However, the high percent of children in state custody and in out-of-home placements indicates that many of the children were already estranged from their families before entering the programs being studied. This may have contributed to the finding that only 34% of the children were in the custody of a family member after 12 months in the program. Many of the children had not been involved with their family for a long period of time.

Child Functioning Indicators. The results from measures of emotional and behavioral functioning (CBCL & YSR), and functional impairment (CAFAS), are very encouraging. Scores at the 12 month interval were significantly lower than at program entry, indicating a reduction in emotional problems and functional impairment. Results from the RBPC also indicated improvement in this domain but only the conduct disorder scale yielded a significant difference. The extreme level of emotional problems in these children is indicated by the finding that even though their scores on the CBCL are significantly lower after 12 months of treatment, the mean is still in the clinical range. The mean for the YSR, however, below the clinal range at post-test.

Scores on measures of academic performance taken at the 12 month point are also encouraging. While the average achievement level may still be below expected grade level, the means for both reading and math were significantly higher after 12 months. Results from testing in these programs indicate that children with serious emotional disabilities can improve academic performance and reverse the downward spiral of poorer and poorer test scores. All of the other scales such as self esteem and the SSRS yielded results that indicated improvement after 12 months but the differences were not statistically significant. Likewise, the measures of family functioning and impact on family yielded non-significant differences though they showed improved status. The results from the latter two measures may have been influenced by the small number of families available to complete these scales.

Services and Placement Outcomes. There were 47 different services that children in the study received. These ranged from out patient mental health to supervised living services. We reduced the 47 different services to 11 different categories and found that 80% of the children received between four and seven different categories of service. All children received case management.

After 12 months of treatment, we evaluated the restrictiveness of living arrangement and school placement. In terms of where they lived, 40% were in less restrictive settings, 32% at the same level, and 28% were living in a more restrictive setting. In school, 31% were in a less restrictive setting, 56% were at the same level, and 13% were taught in a more restrictive setting than at program entry.

These initial results are viewed as promising and indicative of improvement in the functioning of children who have serious emotional disabilities when treated in a community based program. The results should encourage continued examination of community based services employing rigorous research designs.

Return to Top

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Return to Top

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Return to Top

Return to Symposium Menu

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Coming Home: The Full Inclusion of Children with Serious Emotional Disturbances

Author
Introduction Method Results Discussion References
Return to Table of Contents

Introduction/Purpose

In 1993, the Nebraska Department of Social Services contracted with the Center for the Advancement of Human Development (the Center) to design and implement community-based mental health/child welfare services in two service districts in Nebraska. The purpose of this contract was two fold: (1) return adolescents who were placed in out-of-state institutions; and (2) prevent adolescents from being placed in out-of-state institutions by serving referred youth. The Center was also required to identify psychosocial variables associated with various aberrant youth behavior and identify the level of community tolerance of those behaviors.

In response, the Center developed two group living programs, specialized therapeutic foster care, home-based therapy, and family support services. The Center developed the capacity to receive 20 adolescents into care within the first 40 days of operation and developed 10 therapeutic foster care families within 10 months. In April, 1995, the Center began the process of acquiring 23 family support workers to provide a total of 3,680 hours of family support services per month, and is implementing an in-school wraparound program. Additionally, the Center was awarded an expansion contract to include two additional districts in Nebraska.

To develop the service system, the Center and the Nebraska Department of Social Services agreed to a purchase of service arrangement beginning on day one of the contract. System financing was accomplished through a 60 day pre-payment consideration with very aggressive utilization rates and outcomes established as contract stipulations for the two year contract period.

Fiscal outcome data strongly demonstrated significant cost savings to the State of Nebraska. Clinical outcome data strongly supported the inclusion and integration of youth into community programs including public education, and the further use of less restrictive levels of care for this population. However, data also indicate that certain youth and adolescent behaviors present serious barriers to community inclusion efforts. Identifying the variables associated with various child behaviors has permitted an early identification of those children who show a very strong probability of experiencing extreme difficulties in school. Extreme behavioral difficulties in school were predictive of community exclusion in favor of a placement in a locked correctional facility. Prior to this project, program evaluators were limited to capturing this information after the child had been excluded. This project has provided a mechanism to predict which children will experience extreme levels of behavioral difficulties in order to develop intervention strategies before the child enters school.

Return to Top

Method/Procedures

Service Outcomes as Contract Stipulations

The Nebraska Department of Social Services and the Center agreed that much of the service system in Nebraska has been developed in the absence of empirically derived information. Programs have been funded, children have been placed, and policies developed based largely on lobbying efforts, story telling, and clinical intuition. In an effort to change the 'standard operating procedure,' the Nebraska Department of Social Services and the Center agreed to include service outcome measures as contract stipulations in an effort to establish strategies to promote empirically derived information sources which could inform multiple users of service, policy makers, clinical professionals, and others interested in the issues of treating children with emotional disturbances. In that spirit, the Center and the Nebraska Department of Social Services agreed to the following:

1. The Center would build a service system which would be comprised of group living, therapeutic foster care, intensive family preservation services, and school supportive services in two rural districts to respond to the individual mental health needs of children who were placed out-of-state in long-term psychiatric care facilities, and to return those children to the home districts. All employees of the system would be hired from the local communities.
2. As an incentive to return these children as soon as clinically possible, the Center received 60 days pre-payment on a two year contract as a function of program initiation. The Center would be required to maintain a utilization rate better than 96% after the first 40 days of program service.
3. All youth and adolescents would be served by the local public education system, with the expressed desire that all children be fully integrated into regular education classes, with special education supportive services provided within the regular education setting if required.
4. Empirically derived program as well as child/family indicators would be developed and fully implemented with the aim that those indicators and outcome variables would be used to identify precise difficulties in serving these and similar adolescents and families in rural settings.
5. The Center would maintain a "no reject" policy regarding children admitted to the system of care.
6. The Center would develop further program components at discharge based upon the identified needs of each child (wrap around model of service provision; independent living).

Subjects
The Center obtained a complete set of data on each adolescent served. The first program component 'on-line' was the group-living facilities, which served all of the children returned from out-of-state institutions. All adolescents categorized as the prevent from going out-of-state' group received services from the group-living facilities as well. Child demographics are shown in Table 1.

It should be noted that the Group Living programs also provided 213 days of emergency and temporary (less than 15 days average length of stay) care for an additional 19 adolescents.

The adolescents served were primarily older, with long histories of placements in very restrictive placements. Many of these youth did not possess age appropriate social skills, or problem-solving strategies. In the face of confrontation or frustration, they would frequently resort to temper tantrums or destructive out-bursts, followed by requesting 1:1 therapy sessions. Most of the children had not attended a public school for more than two years.

Return to Top

Measurement/Instrumentation

In an attempt to identify problem-prone child behaviors associated with the two most influential contextual settings in which youth must participate, the Center employs the following instruments:

1. Daily Adjustment Indicators (DAI; Burchard, 1990). The DAI is a 25 item (binary) behavior checklist designed to be completed by adult caretakers on a daily basis across all living environments.

2. Eyberg Child Behavior Inventory (ECBI; Eyberg, 1992). The ECBI is a 36 item behavior checklist that allows the adult to rate each child behavior from never to always and permits a second rating per behavior on a second adult dimension: Is this [behavior] a problem for you? Adult direct care providers complete this checklist monthly. This inventory yields a total problem score and a total intensity of behavior score for each child
3. Sutter-Eyberg Student Behavior Inventory (SESBI; Sutter & Eyberg, 1992). The SESBI is a 36 item behavior checklist that allows the teacher to rate each child behavior from never to always. This inventory also rates a second caretaker dimension: Is this [behavior] a problem for you? Teachers complete this checklist every other month. As with the ECBI, measures include a total problem score and a total intensity of behavior score for each child
4. Community-Oriented Programs Environment Scale (COPES; Moos, 1987). This instrument, designed for community-based treatment programs (e.g., board and care homes, sheltered workshops, and halfway houses), includes 100 items, 10 subscales, normed on 74 programs. Youth rate their living environment using COPES every other month.
5. Achenbach Youth Self-Report (CBCL; Achenbach, 1983). Youth complete this 112 item behavior problems checklist at intake and discharge.

Return to Top

Results and Implications

By returning these targeted adolescents, the State of Nebraska received an annualized savings of $1,067,621.00. In other words, in the absence of this service, Nebraska would have spent an additional $1,067,621.00 during the fiscal year. These actual savings were used by the Nebraska Department of Social Services to 'sell' the service system to policy makers, and argue the legitimacy of alternative levels of care for very seriously involved adolescents.

Preliminary data analysis included performing various correctional analyses, analysis of mean scores, and regression analysis. Very early in this work it was determined that separating the data by 'time in service' provided very useful information.

The children and youth demonstrated sufficient variability from month to month on the Daily Adjustment Indicators and the COPES. A description of the DAI can be seen in Table 2.
It is important to recognize that the first month data does not represent a full month 'in care.' It represents the month the youth entered the program. In other words, the data is representative of some portion of the total days of the month the child was in care. The second month actually represents the first full month of data (see Table3).
The COPES permits an analysis of the child's perception of his/her living environment. Generally, the lower the score the less the child is engaged in his/her living situation.

The regression analysis was designed to answer the following two part question: Which criterion variable, (the youth's Sutter-Eyberg Student Behavior Checklist score or Eyberg Behavior Inventory Intensity/Problem score), and what set of predictor variables (DAI) and (COPES), would result in the best predictive model?

Being able to answer the above complex question could equip program staff to quickly evaluate a youth's potential for problems in different environments based upon an earlier assessment. These instruments are completed by the youth, the program staff, and school personnel, thus representing multiple informants in different settings. Provided that a meaningful model could be built, such a statistical model could promote more comprehensive clinical and program decisions.

For example, it was determined that in general, elevated Physical Aggression scores and elevated Verbal Abuse scores in the residential setting were predictive of serious problems in school (Sutter-Eyberg

Behavior Checklist -Intensity of Behavior Score). In other words, if children, demonstrated elevated scores on these DAI dimensions, they tended to have extreme difficulties in the education settings as well. It should be recognized that this pattern held true regardless of age or community in which the youth was served.

The second analysis involved the COPES scores with the DAI dimensions against the Sutter-Eyberg scores. A slightly different but more complete picture emerged after this analysis. There was an interaction effect between the COPES scores and the two DAI dimensions. However, Physical Aggression scores at month two and three and the COPES score tended to be the best predictors of behavioral difficulties in the educational setting. Children scoring the lowest on the COPES tended to score the highest on the Physical Aggression dimension, and had the most difficulties (behaviorally) in school.

Our full analysis indicated that the children scoring the lowest on the COPES tended to be the children that obtained the highest scores on Physical Aggression at months two and three; had extremely elevated scores on Verbal Aggression, had the highest Sutter-Eyberg Intensity Scores, and did not remain in school, or the community. In fact, the children who statistically fit this profile were eventually targeted first by the school; referred to the county attorney's office by school personnel, received a new petition (delinquent) by the county attorney, and placed in Nebraska's correctional facilities after a hearing by a county judge.

It should be noted that each of these targeted children had past delinquent charges, and were not citizens of the communities were they received residential or educational services.

Return to Top

Discussion

The current data indicate that these children did act very differently from the other children in care, regardless of the county of origin. However, the associated 'characteristics' are important considerations at this point in the analysis. What defines these children as a 'set' vs. other children whose scores are similar becomes critical when developing both clinical interventions and administrative positions. Were these children treated differently somehow? If so by whom? Did these children fail to 'fit' into the community's picture of youth who should be served by community services?

Clearly, the educational settings played an important role in the identification and referral process to the county attorney's office. If providers are to successfully serve troubling children, it is important to be able to recognize those children who demonstrate an elevated risk of being removed from communities, and to introduce interventions aimed at changing that trajectory. Educational settings represent important spheres of community influence&shyp;as schools began to encounter difficulties beyond their ability to manage, they may engage the local county attorney's to invoke various legal mechanisms to relieve the pressure. These mechanisms can result in charges being filed on targeted youth and placement in correctional facilities, by-passing less restrictive interventions.

The local school authority's use of the county attorney's office appears to a method of defining the parameters of acceptable adolescent behavior and asserting the community threshold of tolerance. Although it is too early to clearly articulate the behaviors associated with that threshold, it is obviously interactive, and subject to change through social intervention at the school level. With the accumulation of additional data a more precise picture will emerge.

Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

Table 1

Return to Article

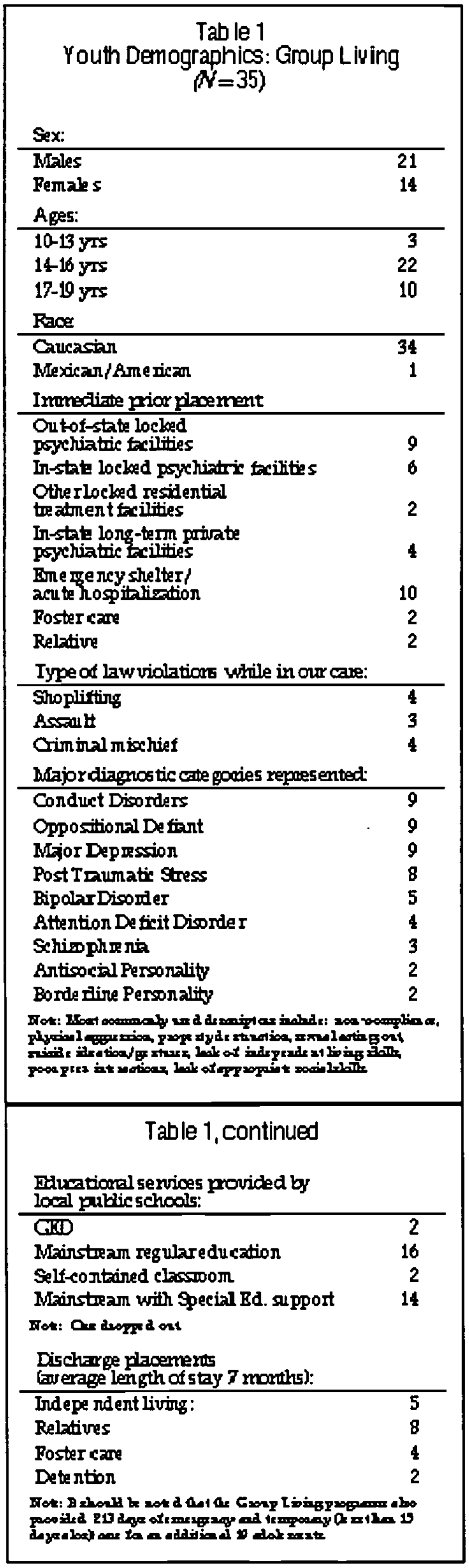

Table 1
Youth Demographics: Group Living
(N=35)

Sex:	
Males	21
Females	14
Ages:	
10-13 yrs	3
14-16 yrs	22
17-19 yrs	10
Race	
Caucasian	34
Mexican/American	1
Immediate prior placement	
Out-of-state locked psychiatric facilities	9
In-state locked psychiatric facilities	6
Other locked residential treatment facilities	2
In-state long-term private psychiatric facilities	4
Emergency shelter/ acute hospitalization	10
Foster care	2
Relative	2
Type of law violations while in our care:	
Shoplifting	4
Assault	3
Criminal mischief	4
Major diagnostic categories represented:	
Conduct Disorders	9
Oppositional Defiant	9
Major Depression	9
Post Traumatic Stress	8
Bipolar Disorder	5
Attention Deficit Disorder	4
Schizophrenia	3
Antisocial Personality	2
Borderline Personality	2

Note: Most commonly used descriptors include: non-compliance, physical aggression, property destruction, sexual acting out, suicide ideation/gestures, lack of independent living skills, poor peer interactions, lack of appropriate social skills.

Table 1, continued

Educational services provided by local public schools:	
GED	2
Mainstream regular education	16
Self-contained classroom	2
Mainstream with Special Ed. support	14

Note: One dropped out

Discharge placements (average length of stay 7 months):	
Independent living:	5
Relatives	8
Foster care	4
Detention	2

Note: It should be noted that the Group Living program also provided 213 days of emergency and temporary (less than 15 days each) care for an additional 19 adolescents.

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[Home] [Search] [Index]

Table 2

Return to Article

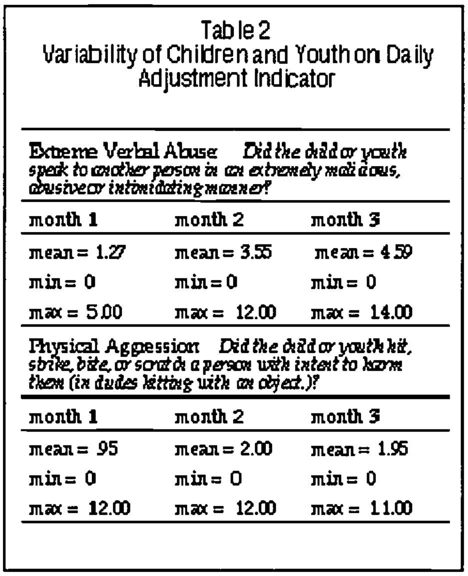

Table 2
Variability of Children and Youth on Daily Adjustment Indicator

Extreme Verbal Abuse *Did the child or youth speak to another person in an extremely malicious, abusive or intimidating manner?*		
month 1	month 2	month 3
mean = 1.27	mean = 3.55	mean = 4.59
min = 0	min = 0	min = 0
max = 5.00	max = 12.00	max = 14.00
Physical Aggression *Did the child or youth hit, strike, bite, or scratch a person with intent to harm them (includes hitting with an object.)?*		
month 1	month 2	month 3
mean = .95	mean = 2.00	mean = 1.95
min = 0	min = 0	min = 0
max = 12.00	max = 12.00	max = 11.00

[Home] [Search] [Index]

Table 3

Return to Article

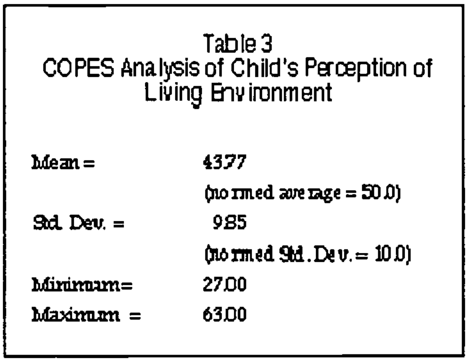

Table 3
COPES Analysis of Child's Perception of Living Environment

Mean =	43.77
	(normed average = 50.0)
Std. Dev. =	9.85
	(normed Std. Dev. = 10.0)
Minimum=	27.00
Maximum =	63.00

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Challenges to the Use of Respite for Children Receiving Short-term In-home Psychiatric Emergency Services

Authors

Introduction Methods Results Discussion References

Return to Table of Contents

Overview

Each year, numerous children, adolescents, and their caregivers seek help in psychiatric emergency settings. Although the mental health field lacks standardized approaches to treat these children and to support their families (Rosenn, 1984), short-term, intensive, in-home interventions modeled on the Homebuilders program (Fraser, Pecora & Happala, 1991) are being widely disseminated.

In 1987, the New York State Office of Mental Health (NYSOMH) established Home-Based Crisis Intervention (HBCI) as an intensive in-home service option for families. HBCI is modeled on the Homebuilders program, which provides short-term services to families with a child experiencing a psychiatric crisis. In 1993, the NYSOMH received a three-year research and demonstration award from the Substance Abuse and Mental Health Services Administration (SM-50357) to study the delivery of in-home crisis services. In this project, two new intensive in-home psychiatric emergency programs for children and their families&shyp;an enhanced version of Home-Based Crisis Intervention (HBCI+) and Crisis Case Management (CCM)&shyp;were implemented and are being compared to the existing HBCI program. In-home and out-of-home respite services are additional supports available to families assigned to the HBCI+ and CCM conditions. This summary describes the respite services available to parents in the HBCI+ and CCM conditions, examines the use of respite in these programs during the first year of the project, identifies the barriers to the use of respite raised during a focus group conducted to increase respite use and the steps implemented to minimize identified barriers, and compares the profiles of children and families who use and do not use respite. Only families who completed the full intervention are included in this analysis.

Return to Top

What are the respite services available to families as part of this study?
In-Home Respite: For families enrolled in the HBCI+ and CCM programs, in-home respite has been made available on both an emergency and planned basis. In-home respite is provided by workers specifically trained to care for children with significant mental health needs. Services to a family are typically provided by the same respite care provider who is selected to match the needs of the child and the family. Given the cultural diversity in the Bronx, English and Spanish speaking respite care providers are available. In-home respite services are also not required to specifically take place within a family's home. Respite care providers can engage in recreational activities with a child such as going to the zoo, seeing a movie, or taking a trip to the mall. A separate pool of money is available to cover the costs associated with such activities. Additionally, in-home respite services are not restricted to the identified child (i.e., the child receiving either HBCI+ or CCM), but also are available for his/her siblings.

Out-of-Home Respite: Out-of-home respite care is also available to families enrolled in the HBCI+ and

CCM programs. In out-of-home respite, a child is taken into the home of a trained respite care family. Out-of-home respite providers were hired and trained by a private agency licensed by NYS to provide such service. Given the short-term nature of the intervention in this project, out-of-home respite stays are limited to three days per occasion, but there is no limit on the number of instances in which it may be used. As is the case with in-home respite, out-of-home respite is available on both an emergency and planned basis. Respite is also provided by the same respite care family, to the extent possible, for families using out-of-home respite on multiple occasions. As possible, respite homes are selected to match the needs of the child and the family and both English and Spanish speaking respite providers are available. Out-of-home respite can also involve extended days that do not require an overnight stay.

Return to Top

How has the use of respite during the first year of the study corresponded with prestudy projections?

In-Home Respite: It was projected that 3,480 hours of in-home respite would be used during the first year of this project (58 families x 6 weeks x 10 hours per week = 3,480 hours). As shown in Figure 1, examination of the 59 families enrolled in the two study conditions (CCM and HBCI+) with access to in-home respite indicates that 16 families (27%) used this service. These 16 families used 847 hours or 24% of the available in-home respite hours (see Figure 2). The number of hours of in-home respite services that families received ranged from 2 to 106 hours, averaging 41 hours.

Out-of-Home Respite: It was projected that 400 days of out-of-home respite would be used during the first year of this project. The same 59 families enrolled in CCM and HBCI+ during the first year also had access to out-of-home respite. Three families (5%) used this service (see Figure 1). These 3 families used 11 days or 3% of the available out-of-home respite days. As shown in Figure 2, the number of days of out-of-home respite services that families received ranged from 2 to 5 days, averaging 2 days.

During the first year of the study the use of both in-home and out-of-home respite fell below anticipated levels. Over two thirds of the families with access to in-home and out-of-home respite did not use either service. The majority of the families using respite used in-home service. Only three families used out-of-home respite.

Why has the use of respite during the first year of the project been below anticipated levels?

As part of the project data collection schedule, parents are interviewed at discharge. During the interview, parents whose child was enrolled in one of the two programs with access to respite are asked about their knowledge of these services. An examination of their responses indicates that nearly 62% of the parents remembered being informed about the availability of in-home respite while 59% recalled being told about the availability of out-of-home respite. In excess of one-third of the parents were unaware of the availability of both in-home and out-of-home respite.

Additionally because many of the families who had been informed of the availability of respite services had not used them, a focus group was conducted to discuss issues related to the use of respite. Focus group participants included in-home and out-of-home respite providers, HBCI+ and CCM providers, staff from the two hospital intake sites, parents, research staff, and program personnel. In all 21 individuals with varying perspectives and opinions concerning the use of respite services were convened for a three hour session to identify obstacles preventing the use of respite and to develop strategies for minimizing these obstacles.

During the focus group, participants identified 37 obstacles limiting the use of respite services. These obstacles were then sorted into like categories by five external raters and the joint proportion matrix was factor analyzed resulting in ten obstacle groupings which are summarized in Table 1. As shown in this table, parents and services providers' need for more information was identified as an obstacle limiting the use of respite. Parents expressed having many unanswered questions about respite and services providers indicated they were not clear about what respite entailed.

It was also acknowledged that respite had a negative connotation and was viewed by parents and services providers as the first step in removing a child from the home. Parents believed that using respite signified they were not doing a good job taking care of their child, and services providers expressed reservations about the therapeutic value of respite.

Issues involving choice and flexibility were also identified as obstacles. Parents did not feel they were given a role in planning respite services and did not have an opportunity to assess the respite services. It was believed that children could not be matched to respite providers and that respite could not be accessed on an as needed basis.

Other obstacles raised during the focus group related to the safety of children during respite care. Both parents and service providers wanted information about the recruitment, training, and supervision of respite providers.

Return to Top

What actions have been taken to minimize the obstacles limiting the use of respite identified during the focus group?

1. Informational brochures have been developed.
2. To provide complete and accurate information on the respite services, separate brochures have been developed detailing in-home and out-of-home respite services and are available in both English and Spanish. Brochures are given to families by the services provider and include telephone numbers of individuals who can answer any questions they may have.
3. Respite providers have been placed on retainers.
4. To enhance the flexibility in accessing respite, respite workers have been placed on retainer. This ensures that respite providers are available if and when a family/child decides to use respite.
5. An out-of-home respite family held an "open house" for service providers.
6. So that the service providers could meet a respite familyand become better informed about these services, an open house was held.
7. In-home and out-of-home respite coordinators are informed when a new child is enrolled in the study.
8. To ensure that respite is considered for each child, respite coordinators contact service providers when a child is enrolled in the study to discuss if and how respite services might be helpful to the family.
9. Increased dialogue and awareness regarding respite.
10. Research and program staff routinely discuss respite with service providers. Service providers are now asked to indicate why families did not use respite.

What are the similarities and differences in the profiles of families and children who have used and not used respite services?

Table 2 summarizes the characteristics of families and children who have used and not used respite services. Significant differences were found between respite users and nonusers concerning the number of children in the household and the identified child's age. Families using respite had more children living at home (mean = 3.3) compared to nonusers (mean = 2.2) and the identified child was younger (mean = 10.3 years old) compared to nonusers (mean = 13.3 years old). Additionally, families using respite had significantly lower level of social support (mean = 74.1) compared to families who did not use respite (mean = 89.9; Barrera & Ainley, 1983).

Although not statistically significant, families using respite services were less likely to have an adult in the household who was employed and the identified child was more likely to be living with neither biological parent.

No differences were found in the number of adults living in the household, the maternal caretaker's age or educational level, or the child's race, ethnicity, gender, degree of dangerousness, or primary diagnosis.
Return to Top

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Return to Top

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.Return to Top

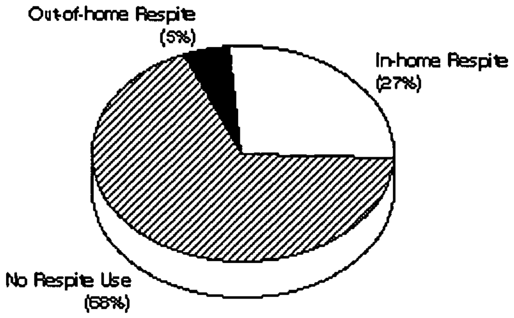
Figure 1

Return to Article

Figure 1

Use of In-home and Out-of-home Respite

(N=59)



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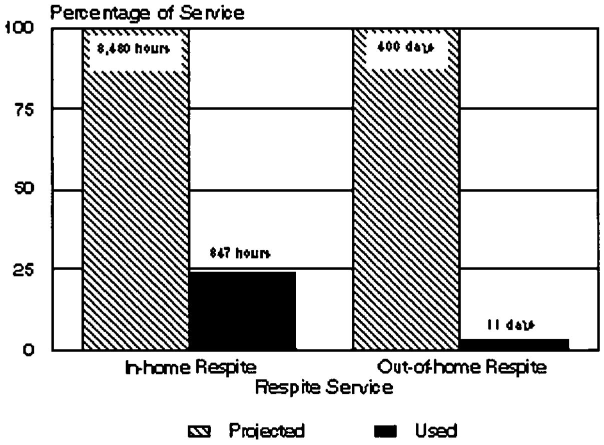
[Home] [Search] [Index]

Figure 2

Return to Article

Figure 2
Comparison of Projected and Actual Use of
In-home and Out-of-home Respite



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[Home] [Search] [Index]

Table 1

Return to Article

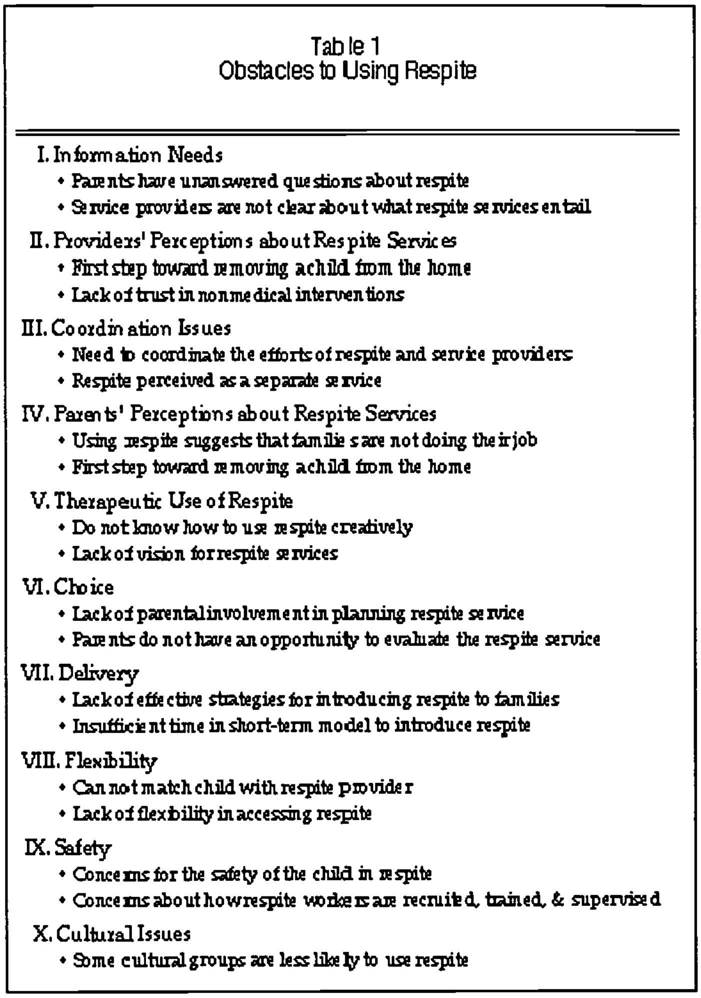

Table 1
Obstacles to Using Respite

I. Information Needs
- Parents have unanswered questions about respite
- Service providers are not clear about what respite services entail

II. Providers' Perceptions about Respite Services
- First step toward removing a child from the home
- Lack of trust in nonmedical interventions

III. Coordination Issues
- Need to coordinate the efforts of respite and service providers
- Respite perceived as a separate service

IV. Parents' Perceptions about Respite Services
- Using respite suggests that families are not doing their job
- First step toward removing a child from the home

V. Therapeutic Use of Respite
- Do not know how to use respite creatively
- Lack of vision for respite services

VI. Choice
- Lack of parental involvement in planning respite service
- Parents do not have an opportunity to evaluate the respite service

VII. Delivery
- Lack of effective strategies for introducing respite to families
- Insufficient time in short-term model to introduce respite

VIII. Flexibility
- Can not match child with respite provider
- Lack of flexibility in accessing respite

IX. Safety
- Concerns for the safety of the child in respite
- Concerns about how respite workers are recruited, trained, & supervised

X. Cultural Issues
- Some cultural groups are less likely to use respite

[Home] [Search] [Index]

Table 2

Return to Article

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Mobile Outreach for Children and Families: An Effective Approach to Stabilization

Authors
Introduction Method Results References
Return to Table of Contents

Introduction/Purpose

Recent years have witnessed a renewed interest in emergency mobile outreach services designed to respond immediately and intensively to persons experiencing psychiatric crises. Various studies have described mobile outreach programs serving adults (Steer, Diamond, Litwok & Henry, 1979; West, Litwok, Oberlander & Martin, 1980), young and elderly adults (Winogrond & Mirassou, 1983), and families, including those with adolescents and/or young children (Bengelsdorf & Alden, 1987; Buchta, Range & Wetzel, 1974; Everstine, Bodin & Everstine, 1977; Kinney, Madsen, Fleming & Haapala, 1977). For the most part, these studies suggest that mobile emergency services are effective in resolving crises and deterring clients from hospitalization. This finding has, however, been called into question by Fisher, Geller and Wirth-Cauchon (1990). In their examination of 1986 data from Massachusetts, those authors found that their results "... fail to support the numerous claims regarding the ability of mobile crisis intervention to reduce the use of hospitalization" (p. 251). In interpreting their findings, the authors do not deny the value of mobile intervention, but rather, call for more rigorous evaluation in order to maximize its effectiveness (p. 252).

Standing in contrast to the conclusions of Fisher, et. al. (1990), are the results of a preliminary study that focused upon the Children's Mobile Outreach program (CMO) offered under the auspices of the organization now known as TRIS Comprehensive Mental Health Services. During the program's infancy, the vast majority of CMO's admissions were children and adolescents whom mental health screeners had originally referred to TRIS for placement in its acute care program, designated as a Children's Crisis Intervention Services (CCIS) unit. It became apparent, however, that after receiving CMO services, many of these clients were stabilized and no longer needed inpatient care. In fact, an initial outcome study (Moore, 1990) found that, during the program's first 18 months of operation, 68.3% of its clients were diverted from admission to more intensive acute care/hospital settings.

The early success of this program, combined with relatively scarce and inconclusive literature regarding mobile mental health intervention, contributed to the decision to undertake the present study. Added to that was the desire to examine the program as it had evolved in response to changes within the environment.

In the years following the original study, the CMO program continued to be regarded as an effective alternative to hospitalization for children and adolescents in psychiatric crises. As the knowledge of the program spread, the majority of referrals were made specifically for CMO crisis intervention services, as opposed to CCIS placement. The program continued to serve children and adolescents who were among the most seriously disturbed, however, due to circumstances arising within the broader mental health care system, it became necessary for CMO to incorporate a new service dimension. Subsequent to the opening of two new community hospital-based CCIS units (with a total of 28 beds), CMO was faced with declining admission rates. The program adapted by extending its services to children and adolescents who were being discharged from the 3 CCIS units now in the region. Retaining its primary goal of deterring children and adolescents from hospitalization, CMO continued to provide initial crisis response to children and families, and now offered adjunct, follow-up "post-discharge" services for clients leaving CCIS settings who required assistance in making the transition back to the community.

Return to Top

Method/Procedures

The present outcome study was undertaken in an effort to determine the effectiveness of the CMO program as modified. Clinical information was obtained from client records and/or directly from clients and CMO staff. All 192 clients served and discharged by the CMO program between January 1, 1992 and December 31, 1992 were included in the study. With few exceptions, referrals to the program originated with local designated mental health screeners, or with the 3 CCIS units (for patients being discharged). Of the clients included, 131 (68%) were community referrals, and 61 (32%) were "post-discharge" referrals in the process of leaving CCIS/hospital settings.

The mobile outreach team, composed of counselors, program managers and a supervising psychiatrist, provided clients with emergency response capability 24-hours per day, 7 days per week. Emergency on-site visits by a two- member team were made in response to crisis referrals and client-initiated crisis calls, and were supplemented by on-going follow-up contacts, again at the client's location (usually home). Services for post-discharge clients were initiated at the CCIS unit prior to discharge, when possible, and were continued at the client's residence within the community.

Of the total number of clients, the majority (82%) received crisis stabilization services, including crisis intervention, psychosocial assessment, counseling, problem-solving, parent training, etc.. However, a significant portion (18%) of both community and post-discharge clients were seen for the purpose of "assessment only," in which case services were short-term and involved collaborative assessment, treatment and follow-up recommendations.

Program effectiveness was evaluated by examining client stability, as assessed by the outreach program treatment team, along with residential status of all 192 clients at the time of their discharge from CMO. Further evaluation of program effectiveness occurred by means of a 6-month follow-up telephone survey. Attempts were made to contact 83 previous clients and their families (selected according to CMO discharge date) to determine the client's status 6 months after CMO discharge. Whenever possible, these telephone contacts were initiated by CMO counselors who were known to the client and family. Of the 83 attempted contacts, 59 (71.1%) were actually completed.

Return to Top

Results and Implications

At the time of their discharge, 67.7% of all clients served by CMO during this 12-month period were viewed as stable. Little difference was detected between community and post-discharge clients, of whom 66.4% and 70.5%, respectively, were considered stable. However, when the 34 clients who had received "assessment only" services were removed from the total, the overall stabilization rate rose to 73.4 percent.

Discharge destinations reflected similar success. Of the 192 clients included, 72.9% were discharged to their homes or foster homes, 4.7% were placed in less restrictive residential settings, and 3.1% were discharged to alternative juvenile justice programs. Taken together, this meant that 80.7% avoided possible admission to an inpatient unit.

The 6-month follow-up survey confirmed that a large percentage of clients remained stable and were able to continue residing in the community. At follow-up, 76.3% of clients and 67.8% of families perceived the client as stable at follow-up. Within the 6-month period following the completion of CMO services, only 2 (3.4%) of the 59 clients contacted were hospitalized and only 4 (6.8%) were admitted to a CCIS unit. The majority (89.8%) remained with their natural and foster families.

The results presented here are consistent with those of the initial CMO study. Together they lend support to the view that short-term, intensive in-home services can have immediate impact upon children and adolescents who are experiencing psychiatric crises, and can thereby reduce the need for admission into acute care facilities. Furthermore, these findings suggest that intensive in-home services can play a significant role in promoting a successful transition to the community, following hospital discharge, possibly reducing tendencies toward recidivism.

Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies,
Florida Mental Health Institute, University of South Florida,1996

Researching a Moving Target: A Study of Inpatient Treatment in the 90's

Authors

Introduction Method Results Discussion References
Return to Table of Contents

Introduction

This paper presents data on children and adolescents moving through inpatient and residential treatment programs.

The study began in 1990, and was designed to study treatment at the Menninger Children's Hospital. At that time, six out of seven hospital units were doing long-term treatment, which averaged one year. We originally designed the study to compare youngsters who received treatment as recommended with those whose treatment was foreshortened by financial constraints. Most treatment in this setting was supported by private insurance.

By 1995, changes in insurance coverage patterns (i.e., few treatments were not foreshortened by financial constraints) and the development of a broader continuum of services prompted a reexamination of the goals of the project. We concluded that there was significant value in attempting to conduct a careful study of the treatment system, using standardized measures to understand and describe the children and families that were served. We felt it important to go beyond the superficial satisfaction and outcome measures required by managed care and accreditation agencies. While recognizing the potential for bias inherent in internal evaluation, we affirm the strengths engendered by having researchers who are familiar with the workings and foibles of a complex clinical system.

Return toTop

Method

Subjects in the study were children and adolescents, ages nine to seventeen, who were admitted to inpatient or residential treatment at the Menninger Children's Hospital. Treatment consisted of comprehensive diagnostic assessment, psychosocial milieu therapy (including groups and individual talks), a specialized school setting, family therapy, and, in most cases, medication and/or psychotherapy. Youngsters and their parents completed semi-structured interviews and questionnaire measures at admission, at discharge from long- term (greater than two months) treatment, and at 18 and 36 months after admission to treatment. Treatment staff also completed behavior checklists after two weeks of treatment and at discharge for long-term patients. Questionnaire measures included the Achenbach Child Behavior Checklist and Youth Self-report as well as a number of other scales; this discussion reports data from the Achenbach scales at admission, discharge from long-term treatment, and 18 month follow-up (Achenbach, 1983; 1991).

Return toTop

Results

Demographic and Descriptive Characteristics

For the first 303 patients included in the study, the mean age was 14.4 years old (sd = 1.9); patients were about evenly divided by gender, with 48% males. Most (91%) were Caucasian, with a mix of other ethnic groups, none representing more than 3% of the total. Socioeconomic status, rated by the Hollingshead 2-factor index, was distributed as follows: I: 21%; II: 28%; III: 22%; IV: 24%; V: 3%.

Half of these patients had no prior inpatient admissions; 16% had one prior, 19% two, 8% three, and 7% four or more prior inpatient admissions. The most common principal diagnoses were affective disorders (40%), and personality disorders (31%). Disruptive behavior disorders represented a significant proportion (18%), and only 5% of patients had a principal diagnosis of a psychotic disorder.

The mean length of stay for the sample was 127 days (sd = 168); the median stay was 37 days. Forty-five percent of the sample stayed less than one month; 20% stayed 1-2 months, 23% stayed two months to one year, and 12% stayed longer than a year. It should be noted, due to changes in insurance coverage and increase in community-based options, the mean length of stay dropped from 207 days for the first 100 patients in the study (median = 57) to 87 days for the most recent 100 patients (median = 27).

At admission, patients reported moderately high levels of problems on the Youth Self-Report (mean Total Problems = 63.8; N = 190); parents reported more problems, with a mean T-score of 73.0 (N = 184) for Total Problems on the Child Behavior Checklist, well into the clinical range. Unit staff, after observing the patients for two weeks, also reported quite high levels of problems, particularly given the limited time frame and contained setting (mean Total Problems = 62.8, N = 257).

Return toTop

Change at Discharge from Long-term Treatment

Multi-variate analyses of variance were conducted to examine the change from admission to discharge on the Internalizing and Externalizing scales, and on Total Problem Scales, of the Achenbach checklists, for self, parent, and staff report. All analyses found significant decreases in problems reported. For the Youth Self-report (N = 46), both Internalizing and Externalizing problems decreased, but overall change was mostly attributable to decreases in reports of externalizing symptoms. Parents (N = 38) reported significant decreases attributable to changes in externalizing symptoms. Clinical staff (N = 65) also observed decreases in symptoms; however, the magnitude of changes they reported was somewhat less, perhaps because they were observing behavior in a constrained setting and a more limited time frame, and they reported mostly decreases in internalizing symptoms attributable to externalizing problems.

Return toTop

Conclusions

In spite of multiple pragmatic and methodological obstacles, including significant organization and staffing changes, these initial results are encouraging. It appears that youngsters in inpatient and residential treatments begin treatment with elevated scores on measures of both internalizing and externalizing problems, and these symptoms do decrease in the course of treatment. Although they appear sensitive to different aspects of improvement, patient, parents, and staff all report significant declines in symptoms at discharge from long-term treatment, and both patients and parents also document this improvement at an 18- month follow-up point. It is notable that short and long-term patients did not show different rates of improvement on these measures; further analyses may separate those patients who have completed treatment from those who had not, and will examine other measures to better understand the impact of different types of treatment.

Return toTop

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Return toTop

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Return toTop

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies,
Florida Mental Health Institute, University of South Florida,1996

Symposium:
Transitional Youth: The Challenges and Service Needs of Youth with Serious Emotional Disturbances as Young Adults.

Maryann Davis, Ph.D.

Authors
Introduction Outcomes Effective Transition Best Practices Conclusions References
Return to Table of Contents

Introduction

Assurance of smooth transitions to the adult service system has been identified as one of the guiding principals of a model system of care for emotionally disturbed children and youth (Stroul & Friedman, 1986). Improvement in helping youth transition to the adult system was one area that Child and Adolescent Service System Program (CASSP) grants funded, and emphasized. However, no states have reported significant progress in this area to the federal agency that oversees CASSP, and many states identify this as an area of weakness (Judith Katz-Leavy, personal communication, Dec 1992).

Complications to such transitions include lack of coordination between child and adult service systems that serve youth with serious emotional disturbance (SED), philosophical differences between the two systems that discourage use of needed adult services, and the common symptoms of conduct disorder and drug and alcohol involvement in the youth population that do not fit the criterion for chronically mentally ill that establish priority populations for the adult system (Stroul & Friedman, 1986). These barriers are assumed to cause many youth in need of services to fall through the cracks between the child and adult system.

The need for transitional services comes at a particularly challenging period in the lives of youth since this is the period during which they are expected to finish school, move on to post-secondary school education/training, obtain employment, develop independence from family, and deepen friendships to build their social network. This is a challenging period for all youth, and youth with SED are much more vulnerable to the pitfalls of this age because of the nature of their disability. Thus, the lack of treatment is believed to have wide-ranging effects on the well-being of this population, and their likelihood of eventually needing more expensive services from the mental health, criminal justice, substance abuse and child welfare systems.

Few researchers, however, have tackled the question by examining outcomes or service needs of children with SED during the years of early adulthood. This discussion presents the results of three outcome studies, a service utilization study and a study of model treatment programs for transitionally aged youth. Findings from these studies form a coherent picture of some of the characteristics and needs of this population, and provide potential programmatic answers.

Return to Symposium Menu

Outcomes

Transition to Adulthood; How are Youth with Severe Emotional Disabilities Different from Non-Disabled Youth?

Mieko Kotake Smith, Ph.D.

Method Results

Return to Symposium Menu

Method

The study sample included 41 students attending special education classes for youth with severe behavior and emotional disabilities in public intermediate and high schools (Severely Behaviorally Disabled students [SBH]), and 41 non-disabled students in the same community (Comparison Group). Personal interviews were used to collect data from students and their parent/guardian. Interviews were repeated in the 2nd and 3rd years. The student questionnaire was based on the University of South Florida's instrument (see Silver below), while this investigator developed the parent questionnaire.

Return to Symposium Menu

Results

Characteristics of the Students: The mean age of the students with disabilities (SBH), and the Control group were 15.44 and 15.57 years respectively. SBH students were predominantly male (76%), while Control students were predominantly female (68%). SBH students were 27% African-American compared to only one African-American student in the Control group. All other students were Caucasian. Chi-square analysis was used to indicate differences between the groups.
Living Situation: The majority of both groups (92% Control, 73% SBH) lived in a house. The majority of Control students (95%) lived in one place during the past 12 months, compared to only 52% of SBH students, suggesting a higher rate of residential instability for the SBH Group. Additionally, 50% of SBH students lived with one parent, while 61% of Control students lived with two parents.

Family: Parent education levels in both groups were similar: 85% of the parents of the Control Group and 70% of those in the SBH Group had completed high school or attained higher education. Group differences were found on several family measures: (1) Approximately half of Control students reported that their family took part in recreational activities at least twice a month, while only 15% of SBH students reported doing so; (2) Significantly more Control students reported being able to discuss sex and other problems with family than SBH students; (3) Almost all Control students reported that their family had a religion, while only two-thirds of SBH students did so.

Social Life: Students in both groups experi-mented with alcohol, but a significantly greater number of SBH students had used drugs ($p < .05$). Also, more Control students belonged to social or community groups, participated in physical activities more frequently ($p < .05$), and more embraced religion than SBH students ($p < .001$). Half of Control students named individuals with whom they had frequent contact (family, peer acquaintances) as their hero, whereas the majority of SBH students name individuals with whom they had no personal contact as their hero (i.e.. sports figures, entertainers). Family members were named as role models more frequently among Control students than SBH students ($p < .05$). Overall, SBH students showed less involvement in constructive social activities.

School: Students in both groups reported that at school they learned many skills, however, they reported acquisition of few job or parenting skills. SBH students received less guidance about getting involved in the community and participated in more vocational planning at school ($p < .001$). Both groups reported positive interactions with school personnel.

Social and Daily Living Skills: Both groups were similar in their social and daily living skills, however, the skills level of SBH students at the third interview was similar to the level of Control students during the first interview, indicating that SBH students lagged behind in this development by about two years.

Services Received: SBH students received significantly more services than Control students, including individual counseling, problem solving training, help in getting along with others, coordination of services, help in getting a job, group therapy, alcohol counseling, and drug counseling.

Life Changes: Fourteen subjects were lost among SBH students (34% loss) during the three year project. Only four Control students dropped out of the study (10% loss). Four SBH student graduated from high school, while 13 Control students graduated. One of the SBH graduates entered college (25%) compared to 85% of Control student graduates. One of each group entered the military, two of SBH students entered the work force (50%).
How to Promote (and Not Interfere with)

Return to Top

Return to Symposium Menu

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Effective Transition

Starr Silver, Ph.D.

Method Results

Youth placed in psychiatric residential facilities are often overlooked in studying transition to young adulthood. This study examined transitional youth in both school and residential settings.

Return to Symposium Menu

Method

The Youth in Transition (YIT) study was conducted in 1990. Young adult subjects (n=215) were randomly selected from a pool of 359 participants, aged 18-22, who were enrolled in the National Adolescent and Child Treatment Study (NACTS). NACTS is a longitudinal study of children with emotional disturbance identified and served by the public education and mental health systems (Silver, Duchnowski, Kutash, Friedman, Eisen, Prange, Brandenburg, & Greenbaum, 1992). In addition to conducting interviews with young adults, a separate interview was conducted with one of their parents (usually the mother; n = 156). The young adult interview instrument contained questions about secondary and post-secondary education and training, employment history, income, marital status, social involvement, and receipt of public-sector services. Parents were interviewed about factors that helped or impeded their child's progress in making the transition to young adulthood.

Return to Top

Return to Symposium Menu

Results

The sample was evenly representative of youth originally served in special education classes (n=106) and residential mental health settings (n=109). The sample is representative of the larger NACTS sample.

Service Needs
Less than 10% (n=21) were currently in high school; a small number (n=15) were in post-secondary settings. High school is a major venue for receiving services, under various federal mandates. Whereas most of these youth received services while there were still in high school or a residential facility, this picture dramatically changed after they left these settings. For example, only 11% of the sample was currently receiving mental health counseling. Rates of service were similarly low for substance abuse treatment (3.8%) and case management (6.9%). In addition, small numbers of young adults reported they currently received assistance with planning a career (10.8%), getting a job (12.9%), or keeping a job (0.7%).

Young adults were asked whether they would like to receive each of the above services. The most desired service was help with planning a career, endorsed by nearly 42% of the sample. Young adults also wanted help with getting a job (34.5%), keeping a job (23.2%), and transportation (21.1%), which may be related to job acquisition and retention. A desire for mental health counseling (23.9%) and help with raising children (24.6%) also was expressed. Parents were asked the following open-ended question: "What did your child need the most to make the transition to adulthood, but didn't get?" Some parents gave more than one answer; therefore, a total of 211 responses were coded. One category of needs was vocational assistance. Twenty-seven of the responses (12.8%) from parents fell into this category. Issues mentioned in this category included skills assessment, job hunting skills, and skills training. The data from the young adults themselves and their parents are consistent in showing the need for further vocational assessment, planning, and on-going support.

A second need endorsed by parents was the need for additional counseling services (38 responses, or 18.0%). This finding dovetails with what was reported earlier on young adults' desire to receive mental health counseling. Other forms of assistance that parents stated their child needed, but didn't get, included help with staying in school (26 responses, or 12.3%), having their child learn independent living skills (19 responses, or 9.0%), and the need for parents themselves to get more support from the system (15 responses, or 7.1%).
Return to Top

Return to Symposium Menu

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Transition to Adulthood: Issues of Youth with Mental Illness

Ann Vander Stoep, M.S.

Methods Results

These studies examined the outcomes of youth discharged from a psychiatric residential program, homeless transition-aged youth with severe emotional impairment, and an entire county's youth who had received mental health services who aged-out of child services.
Return to Top

Return to Symposium Menu

Methods

Study 1. A 5-year longitudinal study, ending
in 1992, included 86 adolescents with serious psychiatric impairment who were consecutive discharges from Washington state's first psychiatric residential treatment program at Seattle Children's Home. Most of the participants in this study did have the type, severity, and chronicity of mental illnesses, such as schizophrenia and major affective disorders, which would gain them access to the adult mental health system.

Study 2. A 3-year prospective study of 50 homeless adolescents living on the streets of Seattle began in 1990. The transition-aged youth in this study had severe emotional experiences of abuse and out-of-home placements. The majority of participants in this study did not have the type nor chronicity of mental illnesses which would gain them access to the adult mental health system.

Study 3. An evaluation of all public children's mental health services in King County, WA was conducted in 1992.
Return to Top

Return to Symposium Menu

Results

It was clear that in King County, adolescents receiving mental health services were not simply a younger cross-section of the adults who receive mental health services. A large proportion of adults receiving mental health services generally did not receive or even need mental health services as children. To a large extent the adult and children's systems treated very different clientele.

In our longitudinal study of 86 of the state's most impaired youth, by several measures of adjustment (e.g, number of episodes of psychiatric hospitalizations, number of arrests, number of days detained, use of crisis line), 19-year olds were having a hard time relative to the years before and after that year. Their participation in gainful activities, school and employment decreased during their nineteenth year. These youth were also more likely than youth reported in the 1980 US Census (BOC, 1982) to be living on their own (16% vs. 8%), and less likely to be living with parents or relatives (37% vs. 83% 18-19yr olds, and 58% of 20-24 yr olds). There has been a trend in our mainstream culture to stretch the apron strings during this transition time; this easement has not been extended to some of our most vulnerable citizens.

Many of the youth in the Seattle Children's Home did meet eligibility criteria for adult services. Often services received were inappropriate. A number who received residential services were placed in group homes and hospitals crowded with older adults who were highly medicated and chronically impaired. For several youth, the symptom which differentiated them from their residential peers was frequent attempts to run away. Other youth qualified for adult outpatient case-management services which did not provide adequate support to help them complete developmental tasks.

In King County, two-thirds of the 17-18 year olds receiving mental health services did not
meet the criteria for adult services. The plight of this population is exemplified by a 17-year old Caucasian male with a diagnosis of conduct disorder and post-traumatic stress disorder subsequent to repeated episodes of physical and sexual abuse, and borderline personality traits. Raised in a family with a history of substance abuse, he had been in the mental health, juvenile justice, and foster care systems since the age of nine. At age 17 he participated in a children's intensive case management program with flexible funding which provided a therapeutic aide who shared his apartment, walked him to school, and tutored him. He received children's day treatment services with biweekly individual counseling sessions, weekly occupational therapy, and psychiatric evaluation, as needed. Many human and monetary resources have been invested in keeping this youth alive, safe, and functional. When he turns 18, however, these resources will no longer be available. Because he does not carry the diagnosis necessary for gaining access to the adult mental health system, he will not be able to receive services, he will no longer have a live-in aid, a counselor, a case manager, medications nor a treatment program. It is possible that he will spend most of his remaining years moving in and out of the correctional system.

So, what leads to good outcomes among this population? Using the longitudinal study data, we examined predictors of adjustment in young adulthood in terms of residential and financial independence, employment, school completion, and minimal days in hospital and arrests within each of three major diagnostic subgroups. We found that attaining a high level of vocational training during adolescence, family supportiveness of residential treatment, participation in outpatient services during the first six months after discharge from residential treatment, and living in a community (as opposed to a residential treatment or hospital setting) at six months post-discharge were related to successful adjustment at three months post-discharge.

Return to Top

Return to Symposium Menu

Service Utilization
Mental Health Service Utilization by Transitional Youth.

Maryann Davis, Ph.D.

Methods Results

This is a study of the mental health service utilization by young adults who were treated in deep-end care as minors in Massachusetts.

Return to Top

Return to Symposium Menu

Methods

Subjects consist of 97 young adults who received treatment in adolescent day treatment, residential or hospital programs for public sector youth between January 1988 and December 1993. Client records were reviewed for all youth in these programs who were between the ages of 19 to 25 on 7/1/92. ID numbers were used to track all Department of Mental Health (DMH) services received between 7/1/92 and 7/1/94 using the computerized client tracking system. The client tracking system records all services received by adults with case managers, and any adult receiving DMH services other than outpatient treatment is assigned a case manager. Group comparisons were made between subjects and a matched control group of other adults in the computer system (age, race, gender & geographic area matched). Thus, adolescents who later received adult services were compared to adolescents who did not, and to the average adult consumer of the same age.

Return to Top

Return to Symposium Menu

Results

Forty-seven percent of youth who received adolescent services received some case manage-ment as adults. There were no differences in the distribution of those who received services (Adult+) and those who did not (Adult-) across adolescent programs. (See Table 1)

There were no significant group differences in primary diagnoses; with a greater percentage of the Adult+ group having a psychotic disorder than the Adult- group, and more of the Adult- group with Conduct, Adjustment and Substance Abuse disorders. The Adult+ group also averaged longer lengths of stay as adolescents, were older when admitted to the adolescent programs, and had more out-of-home

[Home] [Search] [Index]

Table 1

Return to Article

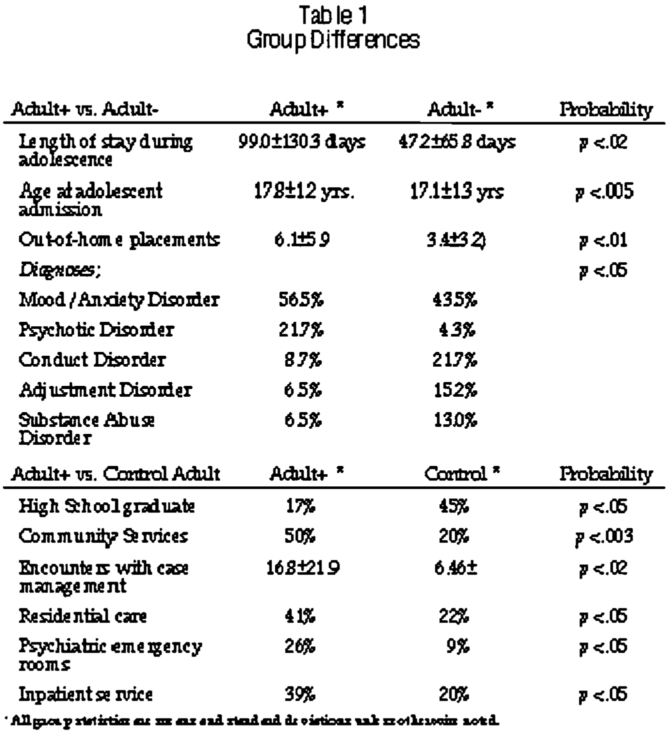

Table 1
Group Differences

Adult+ vs. Adult-	Adult+ *	Adult- *	Probability
Length of stay during adolescence	99.0±130.3 days	47.2±65.8 days	$p < .02$
Age at adolescent admission	17.8±1.2 yrs.	17.1±1.3 yrs	$p < .005$
Out-of-home placements	6.1±5.9	3.4±3.2)	$p < .01$
Diagnoses;			$p < .05$
Mood / Anxiety Disorder	56.5%	43.5%	
Psychotic Disorder	21.7%	4.3%	
Conduct Disorder	8.7%	21.7%	
Adjustment Disorder	6.5%	15.2%	
Substance Abuse Disorder	6.5%	13.0%	
Adult+ vs. Control Adult	**Adult+ ***	**Control ***	**Probability**
High School graduate	17%	45%	$p < .05$
Community Services	50%	20%	$p < .003$
Encounters with case management	16.8±21.9	6.46±	$p < .02$
Residential care	41%	22%	$p < .05$
Psychiatric emergency rooms	26%	9%	$p < .05$
Inpatient service	39%	20%	$p < .05$

* All group statistics are means and standard deviations unless otherwise noted.

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placements. Additionally, the most common adult diagnosis of the Adult+ group was Psychotic Disorder (40%) followed by Mood Disorder (24%) and Personality Disorder (20%).

This is a markedly different pattern from the pattern of this group in adolescence. Of the seven individuals who were diagnosed as psychotic as adolescents, five (71%) were still diagnosed as psychotic as adults. Of the seven individuals diagnosed as mood disordered as adolescents only one (14%) was diagnosed as mood disordered as an adult. Three were diagnosed as having a psychotic disorder (43%), one with an adjustment disorder and two with other disorders. Fewer of the Adult- group had completed high school than the average adult consumer, but proportionately more had received community-based services, residential care, inpatient services and had been in psychiatric emergency rooms as adults. The Adult+ group had also had more encounters with case managers as adults than the average adult consumer. There were no group differences in marital or custody status.

Return to Top

Return to Symposium Menu

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Best Practices for Navigating Rough Waters: Transition of Youth with Emotional/Behavioral Disorders Into Adulthood

Hewitt "Rusty" Clark, Ph.D.

Methods Results

The purpose of this study was to identify the values and best practices of programs which are preparing and supporting transitional youth for employment, educational opportunities, and independent living.

Return to Top

Return to Symposium Menu

Methods

Two hundred fifty-four programs were nominated and surveyed for site visits. A preliminary survey was mailed to each of these sites requesting basic descriptive data on both the program and its consumers. A second survey was sent to the 91 programs whose descriptions indicated that they were serving individuals with serious emotional/behavioral disorders, and that at least a portion of these individuals was in the young-adult age group. The second survey requesteddetailed information about conditions during the program's last complete reporting year. Nine sites were selected for a site visit. A team of professionals, including a parent advocate, visited each site.

The information gleaned from administrators, staff, agency records, parents, and consumers permitted formulation of recommendations regarding program values and best practices that appear to be critical to the transitioning of these youths.

Return to Top

Return to Symposium Menu

Results

Program varied greatly in the array of supports and services available for consumers within each of the transition domains of employment, education, independent living, and community life. Similarly, they varied in the practices used and the program values that they exemplified. Nevertheless, there were commonalities across all nine programs, embracing the values of: (a) consumer-centered orientation including consumer and family involvement, family-role resolution, acknowledgement of cultural differences, and building on consumer strengths; (b) community-inclusion environments with an emphasis on consumers functioning in community settings alongside persons without disabilities; and (c) continuity from consumer's perspective with a focus on consistency in staff to whom consumers relate and consistency across services. One limitation that most programs voiced, and which is related to the continuity from consumer's perspective value, is the categorical age-determined funding: in which federal/state policy sets arbitrary ages for admission and discharge.

Within the domains that the programs addressed, each program attempted to meet the features of the comprehensiveness of supports and services value. Nevertheless, administrators, staff, and parents at each site identified additional supports and services that were needed for some of the consumers. Although all of the programs were, to some extent, providing flexibility in supports and services, a few of the programs retained categorical components, which were not as individualized or flexible as would be needed to meet consumer's needs for establishing independence.

Regarding the safety-net of support value, one of the programs embodied the concept of unconditional care, and the practice of allowing consumers to identify their sources of support from the individuals around them. Although all of the programs shared practices related to the value of skill development teaching, one program stood out as having the most systematic and effective teaching methods for assisting consumers in acquiring community-relevant skills, particularly in the social-problem solving and life skills areas. This program, as well as a second, had particularly strong commitments to the value of outcome orientation through their systematic consumer/program evaluation and through the tracking of progress for each consumer across multiple goals.

Return to Top

Return to Symposium Menu

Conclusions

It is clear from these studies that youth with SED exiting child-serving systems face enormous challenges. All three outcome studies found that youth with SED, regardless of whether they were in special classes, or in residential psychiatric care, were less likely to finish school, gain employment and have adequate social support. Their ties with their families were more distant, rendering them more dependent on their own abilities, underscoring the need for effective transition policies that help them gain employment, continue training, build social supports and avoid trouble. Smith's study indicated that students showed positive gains from services they had received, but their development was delayed. This points even more strongly to the need for continued service provision to youths who age out of children's services.

It is clear that many youth do not make it successfully to the other side of the services bridge; many youth do not receive any needed intensive mental health services, and others receive developmentally, culturally, and restrictively inappropriate care. It is clear that these youth are aware of their needs, with so many indicating desire for services. However, it is not clear how they should access them, or if they will be judged eligible for those services. Since policies do not support smooth transitions between service systems at this time, it is important to provide youth and their families with information and support so that they can advocate for their rights.

It is also important for parents and all professionals working with these and other systems to begin to coordinate their efforts and work together for effective transition. It is clear that the knowledge is out there to guide better efforts in addressing these young adults' needs. Some wonderful programs, with values that should be carried to the transitional system, are already in place, and able to provide expertise to others. It is important to note, however, that only two of the nine model programs had conducted any kind of outcome assessment. Further research is clearly needed, not only in terms of evaluating specific programs, but also in evaluating the effect of policies as they are developed, and identifying coordinating mechanisms that will be necessary for the variety of transitional service needs that know no agency boundaries.

Evaluation of any transitional intervention will require long-term tracking, since data indicate that several years may be required to see long term effects. Outcomes must evaluated in terms of the domains of educational attainment, employment, community adjustment and quality of life. It is also important that the service systems be evaluated for their impact on the success of interventions.

Some federal progress can be seen in providing services for transitional youth. Public Law 101-476, the Individuals with Disabilities Education Act (IDEA), requires transitional planning for all students with disabilities (including SED). Furthermore, this federal legislation requires that transition services must be included in a student's Individualized Education Plan by age 16. The act recognizes the interagency needs of youth with disabilities, and requires each state to formulate policies and procedures for developing and implementing interagency agreements which describe the role of each agency. The legislation also establishes procedures for resolving interagency disputes. While this legislation may serve as a good model, it still does not address the needs of the many transitional youth who drop out of school, and do not fall under the mandate of the legislation.
States should not wait for legislation to mandate how transitional services for youth with SED must be handled. Most importantly, agencies should take responsibility for this population&shyp;a primary reason that young adults do not recieve needed services is that they fail to meet the eligibility criteria of existing services. This leads to the failure of services to address the developmental needs of young adults who have serious impairments, but are not diagnosed as having a chronic mental illness; who have more capacity for independent living, but need more guidance and support than individuals without emotional disabilities.

Return to Symposium Menu

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Return to Symposium Menu

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Return to Symposium Menu

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies,
Florida Mental Health Institute, University of South Florida,1996

Adolescent Suicide: The Implications of Coping, Family Functioning and Their Interactions for Prevention and Intervention

Authors
Introduction Method Results References
Return to Table of Contents

Introduction

It has become apparent over the past ten years that the role of the family has been identified as an increasingly significant variable with regard to adolescent suicide. Some authors go as far as to say that "family related factors appear to be the most significant contributor to youth suicide" (Husain, 1990). As critical as these variables appear to be, very little information is available about the family characteristics of youths that kill themselves. Furthermore, family characteristics of youths who attempt suicide are often described as a side feature of investigations of other factors, and these generally focus on the family characteristics only after an attempt has occurred. Little is known about those family factors that are precursors to the suicide attempt or about the mechanisms underlying "the relation of family characteristics and social supports to youth suicidal behavior" (Pfeffer, 1989).

Most studies that have attempted to elucidate underlying mechanisms have focused on constructs such as family communication, emeshment, cohesion, flexibility, affective involvement, affective responsiveness, behavior control, roles, and problem solving. Concurrent with the family research on adolescent suicide, a separate body of literature has developed which focuses on adolescent coping skills and their relation to adolescent suicide. These studies suggest that adolescent coping skills are beneficial in therapy situations involving suicide ideation and attempts (Orbach & Bar-Joseph, 1993). It is reasonable to assume that these skills are shaped, in part, by the adolescent's experiences within the family context. Other investigators have suggested that family therapy is an appropriate treatment modality for adolescents at risk for suicide (Berman & Jobes, 1992; Richman, 1986). A logical next step is to investigate the family's impact on adolescent coping skills and to identify potential family interventions focused on expanding the adolescent's coping repertoire.

Family Literature. Adolescents often feel alienation to which the family contributes (Smith, 1981). Some theories suggest that poor communication patterns within the family will promote stress that contributes to suicidal behavior of children (Gould, 1965). Other theories suggest that lack of good mothering results in the child feeling abandoned and unloved (Sabbath, 1969). However, of the studies completed, several characteristics of families appear with consistency: family conflict (Cassorla, 1980; Cohen-Sandler, Berman & King, 1982; Corder, Page & Corder, 1974a; Corder, Shorr, & Corder, 1974b; Davidson, Choquet, & Facy, 1976; Jacobs & Teicher, 1967; Kosky, Silburn & Zubrick, 1990; McKenry, Tishler & Kelley, 1982; Spirito Brown, Overholser & Fritz, 1989a; Tishler, McKenry, & Morgan, 1981; Williams & Lyons, 1976; Withers & Kaplan, 1987); history of family suicide (Barter, Swaback & Todd, 1968; Brent, Kolko, Allen & Brown, 1990; Cassorla, 1980; Corder, Shorr & Corder, 1974b; Davidson, Choquet, & Facy, 1976; parental alcohol/drug abuse (Angel, Taleghani, Choquet & Courtecuisse, 1978; Davidson, Choquet, & Facy, 1976; Slaby & McGuire, 1989); and family violence, especially sepal abuse (Husain, 1990; Knittle & Tuana, 1980; Pfeffer, 1985; Slaby & McGuire, 1989). In addition, many adolescents feel they are not able to communicate with their parents (Corder, Page & Corder, 1974a; Corder, Shorr & Corder, 1974b; Marfatia, 1975) and there is often a feeling of parental rejection or disinterest (Cassorla, 1980; Davidson, Choquet, & Facy, 1976; Husain, 1990; Marfatia, 1975; McKenry, Tishler & Kelley, 1982). Along with this lack of perceived family cohesion, the loss of a parent or significant other (Barter, Swaback, & Todd, 1968; Cohen-Sandler, Berman & King, 1982; Godwin, 1986) can often intensify the feelings of alienation and separation.

Coping Literature. Sadowski and Kelly (1993) believe that youth who attempt suicide have "more maladaptive cognitive-emotional behavior response sets to problematic situations than do psychiatric controls and normal controls." Lower problem solving skills are associated with suicide attempts (Asarnow, Carlson, & Guthrie, 1987; Curry, Miller, Waugh & Anderson, 1992) and Amish (1991) suggests that fewer reattempts result from learning and applying coping skills. One study indicated that social withdrawal was used more frequently by adolescents who are suicidal (Spirito, Overholser & Stark, 1989b). In addition, a number of authors have documented a connection between a diminished problem-solving capacity and suicide (Asarnow, Carlson, & Guthrie, 1987; Schotte & Clum, 1987; Schotte & Clum, 1982). Sommers (1995) indicated that youths who have attempted suicide and those who frequently ideated were less involved with the family and tended to use fewer coping strategies than those who thought about suicide less frequently. Additionally, youth with a history of suicide attempts were less likely to use relaxation and more likely to vent feelings.

Return to Top

Method

Subjects and Procedures

The 410 participants volunteered for this project were obtained from 20-middle, junior, and senior high public and private schools and five adolescent psychiatric units in Ohio between 1992 and 1995. The ages of the participants ranged from 11 to 18 years. Thirty percent were male and 70 percent were female. Minorities represented 7% of the population. Both the participants and their parent(s) participated in the informed consent process. Participants completed the Family Assessment Device (FAD), the Suicide Ideation Questionnaire (SIQ), and the Adolescent Coping Orientation for Problem Experiences (A-COPE). The SIQ was used to divide participants into low and high ideator categories. The initial sample contained 320 youth who scored as low ideators, 71 who were categorized as high ideators, and 19 who were placed in the attempter category. The FAD data were Q-factor analyzed separately for each group using QUANAL (VanTurben, 1975). Differences in participant coping skills along topologies were then identified.

Return to Top

Instruments

All of the instruments were developed, normed, and have reading levels appropriate for the sample populations The validity and reliability estimates of the instruments were deemed to be acceptable. The SIQ consists of either 15 (ages 13 -14) or 30 (ages 15-18) items which range in specificity of suicidal ideation. The respondent rates each item in terms of frequency within the last month. Previously determined cutoff scores were used to categorize participants according to level of ideation and, therefore, risk (1988). The FAD was developed to describe family functioning in terms of transactional and systemic properties (Epstein, Baldwin, & Bishop, 1983) and consists of 60 items comprising seven scales which measure Problem Solving, Communication, Roles, Affective Responsiveness, Affective Involvement, Behavior Control, and General Functioning. The A-COPE was developed as a tool for measuring coping skills within the context of the Resiliency Model of Family Stress, Adjustment and Adaptation (Patterson & McCubbin, 1991). It consists of 54 Likert-type items comprising twelve scales which measure ventilating feelings, seeking diversions, developing self reliance and optimism, developing social support, solving family problems, avoiding problems, seeking spiritual support, investing in close friends, seeking professional support, engaging in demanding activity, being humorous, and relaxing.

Return to Top

Results and Implications

The low ideator sample was randomly divided into five subsamples. Each subsample's FAD data were Q-factor analyzed separately. The profiles from each subsample were then compared. (See Figure 1)A single stable profile was identified (N = 83). The high ideator sample was randomly divided into two subsamples and treated in a similar fashion, and one stable profile was identified (N = 23). Because of the small sample size, the attempter data were not cross validated. Again, only one profile was identified (N = 9). These profiles are presented below.

The individuals belonging to the attempter profile differed most from those belonging to the high ideator profile in their perceptions of roles, communication, and affective involvement. Similarly, the perceptions of individuals belonging to the low ideator profile differed most in terms of roles, communications, and affective involvement.

Coping skills as measured by the A-COPE also varied by profile. The youths in the attempter group were different from those in the high ideator group in that they tended to utilize problem solving (t = 2.04, p = .05, N = 32), spiritual support (t=2.0, p = .007. N = 32), and professional support (t = 2.48, p = .019, N = 32) to a greater extent. Youths who fit the attempter profile differed from those with a low ideator profile in that they tended to used spiritual support (t = 2.26, p = .026, N = 92) and professional support (t = 6.17, p = .000, N = 92) to a greater extent, and were less likely to endorse optimism (t = 1.84, p = .07, N = 92) and avoiding problems (t = 3.24, p = .002, N = 92). Those youths who scored as high ideators differed from low ideators in that they tended to seek professional help (t = 2.63, p = .050, N = 106) to a greater extent were less likely to engage in demanding activities (t=2.22, p = .029, N = 106), avoid problems (t = 3.92, p = .001, N = 106), solve problems (t = 2.45, p = .016, N = 106), use self-reliance (t = 3.07, p = .003, N = 106), and seek diversions (t = 2.94, p = .004, N = 106).

Given the limitations of these data, the following suggestions are offered subject to replication. It appears that adolescents from certain types of families may be at greater risk for high suicidal ideation and attempts, and that both the family characteristics and the adolescent's pattern of coping skills can be used by counselors as an indicator of risk. In addition, since the coping skills vary by profile, attention to shaping appropriate skills may serve both a preventive and therapeutic function. Historically, the teaching of coping skills was accomplished by working with the identified client. However, since these skills are, in large measure, learned within the context of the family, and since their use within the family context may serve a protective function, both the adolescent and the family may be appropriate targets for therapeutic interventions targeted on increasing the adolescent's coping skills.

Return to Top

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Return to Top

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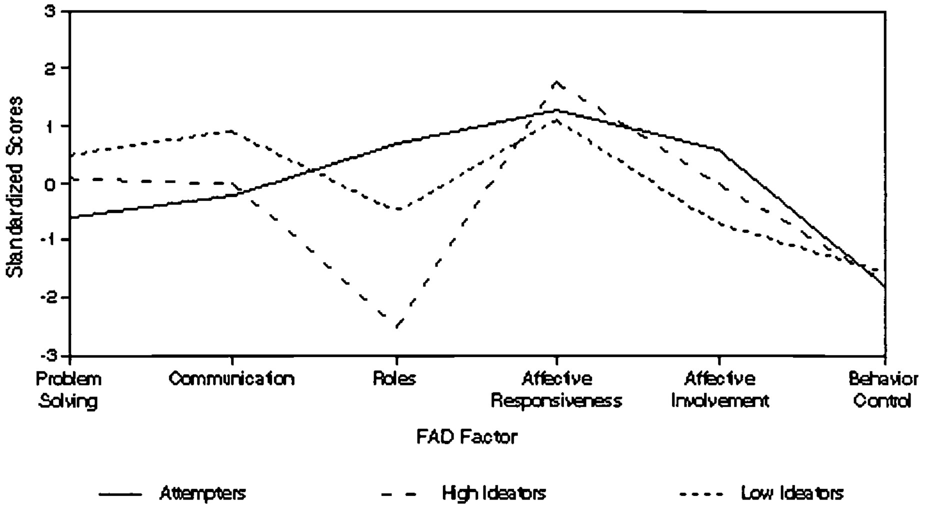
Return to Top

[Home] [Search] [Index]

Figure 1
Return to Article

Figure 1
Low Ideator, High Ideator and Attempter Family Profiles
(N= 410)



[Home] [Search] [Index]

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Gender Appropriate Services for Adolescents with Serious Emotional Disturbances: A Gender Competency Model

Authors

Introduction Methods Results Discussion References
Return to Table of Contents

Introduction

Gender sensitivity and gender competence are emerging concepts in the field of children's mental health. Several areas of research affirm the importance of gender perspectives. First, studies of both adult women and men have found evidence of gender bias in clinicians' attitudes, diagnosis, assessment and treatment (Becker & Lamb, 1994; Broverman, Broverman, Clarkson, Rosenkrantz & Vogel, 1970; Ford & Widiger, 1989; Hoppe, 1984).

Second, feminist researchers have pointed to the impact of gender role socialization on the development of adolescent females' self-esteem, body image, sexuality, and identity (Chodorow, 1978; Dinnerstein, 1976; Gove, 1979; Gonsiorek, 1988; Pipher, 1985; 1994; and Zimmerman & West, 1975). Likewise, male socialization patterns have been found to have a dramatic effect on communication, difficulties with intimacy, conflict resolution, emotional constriction and the consequences of internalized homophobia.

Third, psychologists have begun to acknowledge the importance of addressing gender role socialization patterns in adolescence to prevent the onset and occurrence of adult mental health problems among women, such as depression, dissociation, eating disorders and post traumatic stress disorders (Koss, 1990; Mowbray, Herman & Hazel, 1992; Boskind-White, 1983; Brodsky & Hare-Mustin, 1980; Foa, Olason & Steketee, 1987). No longer can we ignore the importance of gender perspectives in our clinical attitudes, assessment, diagnosis, service development and treatment of youth with mental, emotional, or behavioral problems.

One initiative under Nebraska's Child and Adolescent Service System Program (CASSP) addresses the need for gender sensitive and appropriate mental health and substance abuse services for youth. This summary describes the preliminary results and implications of a statewide needs assessment. We present a Gender Competency Model to provide a developmental framework for enhancing a system of care that is responsive to the gender-specific needs of adolescents.

Return to Top

Method

Delbesq (1983) developed the nominal group technique to allow for idea generation while avoiding the problems of group dynamics. The following steps outline the process for conducting nominal groups:

1. Convene in a large group. Explain the purpose of the meeting, the nominal group process, and the role of the facilitator.
2. Assemble participants into subgroups of no more than seven members and assign a facilitator to

each group. Those selected as participants should be knowledgeable about the issue and represent different perspectives. (We pre-assigned participants to ensure that each subgroup contained representatives of different perspectives.) The facilitator introduces oneself and emphasizes the need for full participation.

3. Present a single question to the group and ask participants to write their own responses. During this phase of the process, it is important that the facilitator ensures the participants proceed independently, without discussion, and in absolute silence. This approach allows each member to ponder upon his or her own ideas, to be motivated by the observance of others writing their responses, and to be involved in an atmosphere where premature decisions do not have to be made.
4. Elicit individual responses in round-robin fashion until all contributions have been made. As responses are stated, the facilitator numbers and records them on an easel thereby ensuring each member's participation. During this time, the facilitator allows no discussion by group members regarding form, format, or meaning of a response.
5. Guide participants to explain the meaning of their responses in round-robin fashion. The purpose of this clarification phase of the process is for the group to have a shared understanding of each response. The role of the facilitator during this step is to direct
6. Direct the participants to select and rank order a specific number of items from the entire list of recorded responses. (In our study, the facilitator asked group members to select and rank seven responses they identified as the most important needs of female adolescents and seven identified as the most important male adolescent needs.)
7. Repeat steps 3 to 6 for each question. (We repeated the process for a second question. The time for the entire process totaled approximately four hours).

The Nebraska Department of Public Institutions, the State Mental Health Authority, employed a nominal group technique (Delbecq, 1983) to assess the gender-specific needs of adolescents receiving mental health and substance abuse services. The Department mailed a letter to 700 randomly selected professionals located throughout the state, inviting them to participate in a needs assessment. The letter was mailed to local, regional, and state policy makers, administrators, directors, therapists, and school counselors. It stated the purpose of the study and detailed the time commitment required of those volunteering to participate.

Three facilitators conducted a total of five, 4-hour nominal groups at two sites&shyp;one urban (Lincoln) and one rural (Kearney). A total of 28 professionals from 24 organizations participated in the study (females = 18, males = 10). Although a majority of the participants were from mental health and substance abuse agencies (71%), 29% represented other child serving entities including education, health, juvenile justice, and advocacy programs. The specific questions posed to the participants were as follows:

- What are the gender-specific needs or issues of adolescents receiving mental health and substance abuse services?
- What changes would you make so that mental health and substance abuse services are responsive to the gender-specific needs of adolescents?

Following the nominal group process, the facilitator asked the first question regarding adolescent needs, elicited responses in round-robin fashion, guided participants toward clarification and asked participants to individually select the 7 most important needs of adolescent females. Participants repeated the selection and priority ranking of needs for adolescent males. The facilitator repeated the entire process (including prioritizing by gender) for the second question regarding recommended changes to adolescent services. Thus, solution generation followed identification of the needs, issues, and concerns of the youth.

Return to Top

Results

The authors examined the content and the rankings of participant responses both within and across the five nominal groups. Similar responses were first combined into a single gender-specific item. Rankings across similar responses were then summed for each item. Finally, items from all five nominal groups were arranged into similar categorical areas and the numerical summed ranks for each item within a category were added together. The resulting value was then assigned to a topical category. The category receiving the highest summed rank represents the top priority area. This process was repeated for both questions.

It should be noted that the organization of similar responses into a gender-specific item and these items into categories was expedited by the nominal group process. During the clarification phase of the process, all participants along with the facilitators, reached a shared understanding of the generated ideas. The authors relied upon this understanding as the basis for categorizing the needs and recommended changes into topical areas.

Gender-specific Needs. In response to the first question, participants identified 65 unique needs, issues or concerns which were then aggregated into 14 topical categories. Table 1 presents the seven top prioritized categories for both females and males. Three issues were seen as important to both females and males: (1) the Lack of Adolescent Services; (2) Violence; and (3) Provider Knowledge.

Recommendations. In response to the second question, participants generated 72 unique recommendations which were aggregated into five topical areas. Table 2 exhibits the five areas in which participants believed changes needed to be made to ensure gender appropriate service provision. The data clearly indicate that professionals believe that the biggest obstacles to meeting the gender-specific needs of adolescents are the lack of services and barriers at the macro-level.

Return to Top

Implications

Building on the results of the present study, we have begun to identify the components of a Gender Competency Model for Adolescents. The Gender Competency Model can provide a framework for understanding the assessment results as well as a process for mobilizing service delivery systems toward gender sensitivity and competence. This inductively grounded model promotes the perspectives of the participants, and rejects any pre-existing categorization.

The Gender Competency Model for Adolescents embraces five domains: (1) Systems Change; (2) Human Resource Development; (3) Community Relations/Public Education; (4) Service Enhancement; and (5) Service Development (see Figure 1). These domains suggest that steps toward gender competency must take place both within and outside of traditional mental health and substance abuse treatment systems. Participation by other systems, including Education, Public Health, Juvenile Justice, and Child Welfare is essential. Community involvement in and endorsement of changes are vital to the successful development of a gender competent system of care for our youth. Most importantly, the identified needs of adolescents can effectively be viewed within the framework of this model.

Another important characteristic of the model is that there is no single approach to developing gender competency. For instance, the road toward competency can begin at the macro-level&shyp;Systems Change&shyp;by adopting legislation designed to address gender issues. These policies can in turn result in increased variety and flexibility in non-treatment based education (Community Relations and Public Education). Another approach may be to inform community members about adolescent issues and the need for gender competent services. Community awareness can then provide impetus for grass roots advocacy for increased provider knowledge and skill development (Human Resource Development).

Return to Top

Conclusion

The nominal group process provides a highly structured, interactive way to generate ideas and solutions rich in information. However, it is important to recognize the limitations of this particular methodology:

- *Sample size.* The group format restricts the number of participants, and participants must be willing and able to commit a significant block of time to the process.
- *Representation.* Our sample did not reach particular subpopulations with valuable perspectives, such as parents of adolescents with emotional, mental and behavioral problems. In addition, Nebraska, a frontier state, has a heavy concentration of rural communities. Site selection reflected this population density.
- *Response Bias.* We noted a potential recency effect from statewide trainings in the area of sexual perpetration. It will be important to triangulate our results with family perspectives, contemporary research, and survey results of current policies, services, training and personnel.

We have argued that the concept of gender competency recognizes the role gender plays in referral, service delivery, differential diagnosis and clinical interventions. The Gender Competency Model is based on the premise that gender responsive services differ from those ignoring the gender-specific needs of our youth. It is developmental, for it recognizes that services, agencies and professionals develop gender competency over time. Gender competent services and systems are those that evolve in gender consciousness by recognizing the centrality of gender in the development, enhancement and provision of services. The next challenge is to use the Gender Competency Model framework to develop specific recommendations regarding systems change, service development, service enhancement, community relations/public education, and human resource development.

Return to Top

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Return to Top

[Home] [Search] [Index]

Table 1

Return to Article

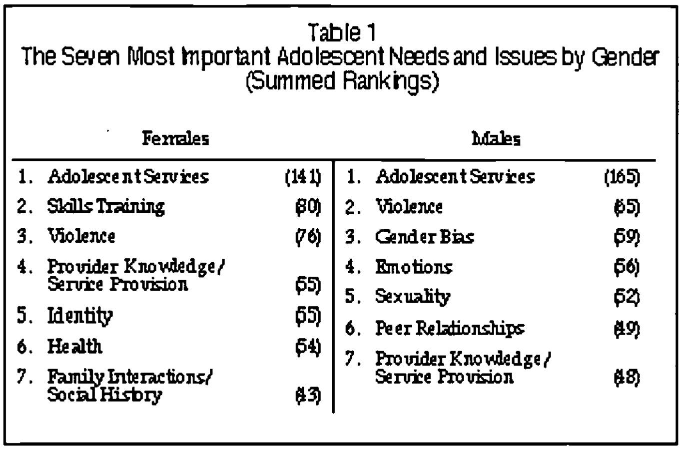


Table 1
The Seven Most Important Adolescent Needs and Issues by Gender
(Summed Rankings)

Females		Males	
1. Adolescent Services	(141)	1. Adolescent Services	(165)
2. Skills Training	(80)	2. Violence	(65)
3. Violence	(76)	3. Gender Bias	(59)
4. Provider Knowledge/ Service Provision	(65)	4. Emotions	(56)
5. Identity	(65)	5. Sexuality	(52)
6. Health	(64)	6. Peer Relationships	(49)
7. Family Interactions/ Social History	(43)	7. Provider Knowledge/ Service Provision	(48)

[Home] [Search] [Index]

Table 2

Return to Article

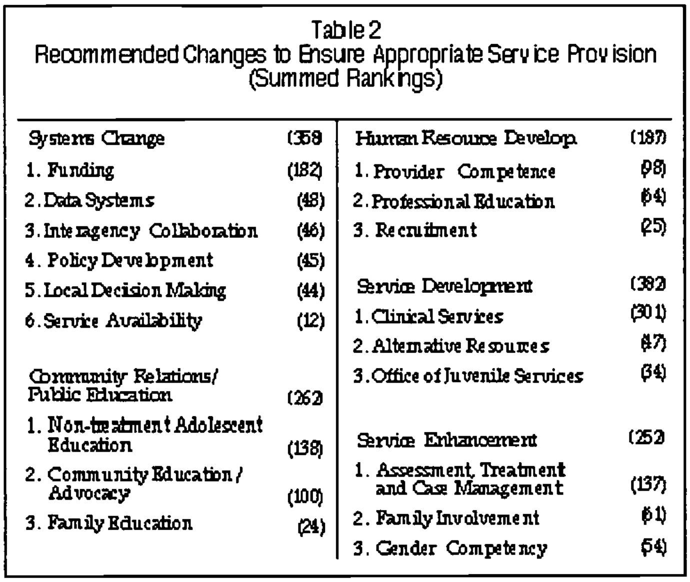


Table 2
Recommended Changes to Ensure Appropriate Service Provision
(Summed Rankings)

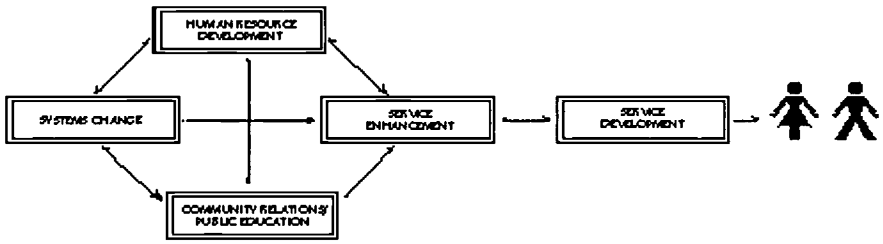
Systems Change	(358)	Human Resource Develop.	(187)
1. Funding	(182)	1. Provider Competence	(98)
2. Data Systems	(48)	2. Professional Education	(64)
3. Interagency Collaboration	(46)	3. Recruitment	(25)
4. Policy Development	(45)		
5. Local Decision Making	(44)	Service Development	(382)
6. Service Availability	(12)	1. Clinical Services	(301)
		2. Alternative Resources	(47)
Community Relations/ Public Education	(262)	3. Office of Juvenile Services	(34)
1. Non-treatment Adolescent Education	(138)	Service Enhancement	(252)
2. Community Education / Advocacy	(100)	1. Assessment, Treatment and Case Management	(137)
3. Family Education	(24)	2. Family Involvement	(61)
		3. Gender Competency	(54)

[Home] [Search] [Index]

Figure 1

Return to Article

Figure 1
Gender Competency Model



[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies,
Florida Mental Health Institute, University of South Florida,1996

Multicultural Mental Health Training Program: A Comprehensive Training Program for Improving Service Delivery to Ethnic Minority Children and Families

Authors

Introduction Methods Discussion References
Return to Table of Contents

Background

Current trends within the mental health field highlight a disproportionately high percentage of minority utilization of services as compared with minority provision of those services (McHolland, Lubin, & Forbes, 1990). Many minority clients do not have access to quality services. In an analysis of the types of mental health services Americans receive, Redick (1994) reported a decrease in the inpatient status of non-minorities and an increase in the inpatient status of minorities. According to the U.S. Department of Commerce (1994) and the 1990 Census Bureau, one third of the United States population will be made up of minority persons in the year 2000.

Researchers have repeatedly reported that minority clients prefer minority counselors; seek counseling more often from non-European-American counselors; terminate prematurely with European-American counselors; perceive mental health institutions as "White Institutions," and are suspicious and/or resistant to treatment; and that minority professionals are more likely to render higher quality services to minorities because of their understanding of the customs and the language of their own minority group (Boyd-Franklin, 1989; Thompson & Cimbolic, 1978; Comas-Diaz & Griffith, 1988; Terrell & Terrell, 1984). However, the impact of minority professionals is limited if their role at policy and administrative levels of mental health programs is overlooked. Zane, Sue, Castro, and George (1982) called for minority representation within the mental health field at higher than para- and practicing-professional levels to ensure the development of innovative services and the broadening of the minority mental health research base. Minority mental health training programs are one avenue toward meeting these challenges.

Return toTop

Program Description

In 1987, the Florida Legislature established a culturally based mental health training program at the Florida Mental Health Institute (FMHI) at the University of South Florida (USF), to serve the state's minority population. The aim was to increase the number of minorities in the mental health professions and to address the mental health needs of minority communities of the state. The original bill proposed a training program emphasizing practical techniques applicable to mental health service delivery in minority communities. In response to this need, FMHI initiated the Multicultural Mental Health Training Program (MMHTP) in 1989. This student fellowship program emphasizes clinical/professional development and cultural diversity training to improve mental health service delivery in the state. Before the establishment of the MMHTP, FMHI started a paid internship program with Florida Agricultural & Mechanical University (FAMU) in Tallahassee, the state's historically black institution of higher education.

The MMHTP is unique in that it combines career development programs with training in culture-specific mental health service delivery.
The program has three general objectives:

1. to interest minority students in mental health careers,
2. to provide students and professionals with training that enhances their effectiveness in serving minority communities, and
3. to provide professional development training that will facilitate minority advancement to positions of influence within Florida's system of mental health services.

The MMHTP consists of a one semester fellowship, full-time internship placement with FMHI. Fellows receive a stipend, averaging $2,000 - $2,500 per semester, to assist them with living and tuition expenses. Fellows spend approximately 32 hours per week (i.e., four 8-hour days) in their practicum. An additional eight hours per week are spent participating in formal training and other activities with MMHTP staff. This summary reviews the fellowship training over the past five years. The training program has three principal components.

Mental Health Practicum

Field work experience is provided in residential and outpatient clinical settings in the students' chosen areas of interest (e.g., with children, adults, or elderly populations). FMHI, other departments at USF and community agencies serve as practicum sites. The fellows learn by experiencing the actual work environment and becoming familiar with the operations of everyday service delivery. Fellows participate in practicum-based internship experiences, develop valuable insights, and learn practical skills for making career choices and facilitating career advancement. The training program allows fellows to explore potential career options, to test theories and practices learned in the classroom, and to develop skills fundamental to successful careers in the multifaceted mental health field. The fellowship training involves demonstration of methods plus opportunities to learn by practice. A feature of the program is the emphasis on marketable employment skills. Fellows must acquire specific skills, (e.g., interviewing clients, group techniques, clinical record keeping), and are evaluated on their performance.

Cultural Diversity Training

The training program is designed to provide fellows with a comprehensive learning experience in the field of mental health services from a multicultural perspective. The training program is intended to prepare ethnic minority students to become mental health professionals by concentrating of the mental health needs of ethnic minority and underserved populations. Through a 13-week, classroom-based training module focusing on self-awareness, knowledge of culture and its functions, and mental health issues affecting ethnic groups, fellows learn to recognize and address cultural barriers to service delivery effectiveness.

Professional Development Training

The professional development component provides fellows opportunities to learn marketable leadership, supervisory, and administrative skills for long-term career advancement. Fellows receive training in such areas as: (1) leadership skills; (2) communication skills; (3) interpersonal skills; (4) career development; staff management, (6) time management; (7) resume writing; and
(8) organizational management. Professional development training includes lectures, written assignments, exercises and role playing. The program includes educational, practical, personal, and organizational instruction; program staff support fellows to help them make short and long term vocational decisions to best meet their interests, needs, experience, and training. Participants receive training to facilitate advancement to positions of influence in the mental health and human services fields.

Other Activities

The program also provides fellows, departmental and university staff with training opportunities such as the Cultural Diversity Workshops for Mental Health Professionals. Additionally, the MMHTP collaborates with the Multicultural Child and Family Project within FMHI's Department of Child and Family Studies on various research and technical assistance projects (Briscoe, 1993). In these activities, the fellows assist in providing technical assistance and training to various community programs that serve ethnically diverse children and families. In this manner, students directly observe and gain exposure to community service and needs (Briscoe, Yang and Wright, 1993). Initially, the program primarily focused on working with undergraduate fellows but has expanded to graduate levels. As a pilot project, the MMHTP evolved from an emphasis on speakers and lecture series to a stronger curriculum-based training approach.

Return toTop

Profiles of MMHTP Fellows

A total of 35 students participated in the MMHTP fellowship program that covers 11 semesters from Fall semester 1989 through Fall semester 1993 (see Table 1). Three different colleges and universities, and nine different majors were represented. Four Fellows had double majors and three participated in a two-semester program. A total of six ethnic groups were represented in the program. Of the 35 participants in the MMHTP fellowship program, 24 (65%) were enrolled in degree programs that require internships. The remaining eleven fellows were not required to complete internships to meet departmental requirements and, thus, participated in the program on a voluntary basis.

Student Follow-up

In the Spring of 1993, a follow-up staff survey of former fellows (N=16) showed that 10 were employed in mental health/human services jobs, two were completing post graduate education, two were completing post graduate education, two were in the process of gaining employment, one was in the armed services, and one was employed in a non-related job. Half these fellows had plans for returning to school in the mental health field, with 12.5% completing postgraduate education.

Before entering the program, 37% of the fellows had previous work experience in mental health/human service fields. Overall, response to the program has been positive. The fellows credit the training as helping them attain mental health positions and professional recognition. As one former fellow commented, "the MMHTP was instrumental in getting my career off to a focused and stable start. I credit the program for the recognition I received as a competent clinician."

Recommendations for expanding the program include the following:

1. Increase the continuum of training offered from high school through postdoctoral;
2. Extend fellowships for additional semesters;
3. Increase emphasis on advance research skills for students;
4. Increase recruitment efforts and participation with other universities and colleges;
5. Work with state and local agencies to expand the number of public service settings from corrections, juvenile justice, mental health
6. and human service programs; and
7. Expand training opportunities and information dissemination for mental health professionals in cultural diversity training.

Clearly, in tomorrow's public service delivery systems and work force, the issues of cultural diversity will have increasing relevancy and urgency. The Multicultural Mental Health Training Program has demonstrated that training and leadership can increase the number of minority students who select mental health and human service careers.

Return toTop

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Return toTop

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Return toTop

Table 1

Return to Article

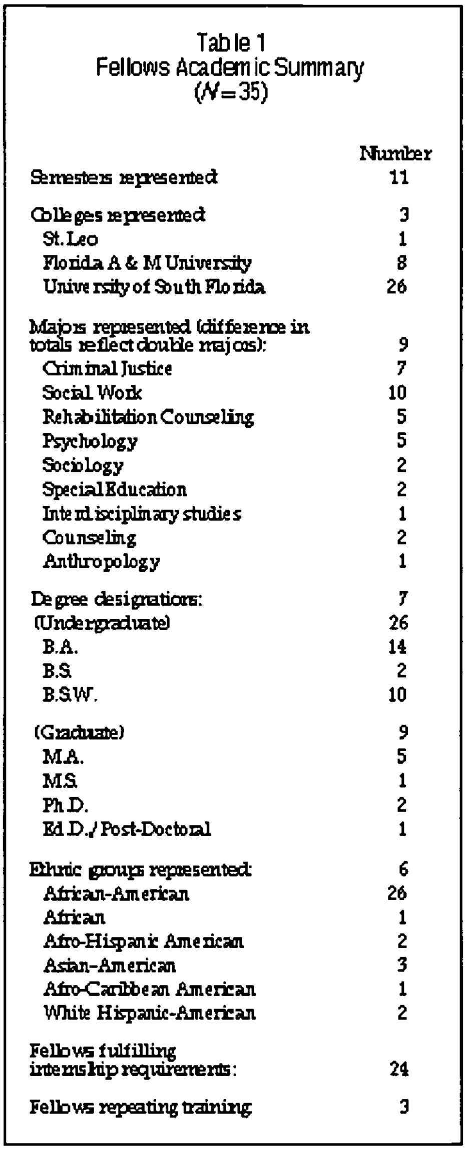

Table 1
Fellows Academic Summary
($N=35$)

	Number
Semesters represented	11
Colleges represented	3
St. Leo	1
Florida A & M University	8
University of South Florida	26
Majors represented (difference in totals reflect double majors):	9
Criminal Justice	7
Social Work	10
Rehabilitation Counseling	5
Psychology	5
Sociology	2
Special Education	2
Interdisciplinary studies	1
Counseling	2
Anthropology	1
Degree designations:	7
(Undergraduate)	26
B.A.	14
B.S.	2
B.S.W.	10
(Graduate)	9
M.A.	5
M.S.	1
Ph.D.	2
Ed.D./Post-Doctoral	1
Ethnic groups represented:	6
African-American	26
African	1
Afro-Hispanic American	2
Asian-American	3
Afro-Caribbean American	1
White Hispanic-American	2
Fellows fulfilling internship requirements:	24
Fellows repeating training	3

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Child Maltreatment and Prenatal Exposure to Alcohol and Other Drugs: Some Preliminary Findings

Authors
Introduction Method Results Discussion References
Return to Table of Contents

Introduction/Purpose

The Juvenile Protective Association in Chicago is currently engaged in a longitudinal study of high risk families. This research is part of a much broader nationwide effort to track approximately 1500 families for 20 years. The Consortium for Longitudinal Studies, funded by the Administration on Children, Youth and Families, National Center on Child Abuse and Neglect, was formed to develop and administer a study of families representing a continuum of risk from moderate to high (Runyan, Curtis, Hunter, Black & Kotch, 1995). The foci of the shared data protocols include delineating adverse outcomes associated with different types of child maltreatment, evaluating the continuum of interventions with regard to impact on children and families, and defining mediating child, parent, family and cultural factors for the child victim.

The Capella Project, located at the Juvenile Protective Association in Chicago, Illinois, is a study of high risk families characterized by households with a history of child maltreatment, extreme poverty, infants prenatally exposed to alcohol and other drugs (AOD), and high exposure to neighborhood violence (Curtis & Schneider, in press). Unlike the other four projects that make up the consortium, the Capella baseline is infancy. Site-specific measures include videotaped, in-home observations of mother and infant social competencies during the first and fourth years.

Return to Top

Method/Procedures

The study is a longitudinal quasi-experiment and was designed to address long-standing, methodological weaknesses in prior studies of the developmental consequences of child abuse and neglect (Howing, Wodarski, Gaudin & Kurtz, 1989; National Research Council 1993). Enhancements include an adequate sample size, comprehensive descriptions of subject characteristics, type and severity of maltreatment behaviors, type, frequency, and length of service interventions, the use of direct observations of mothers and infants, the use of neighborhood controls, multiple-criterion outcome measures, and long-term follow-up.

Utilizing a broad-based ecological and developmental perspective of risk and protection&shyp;including infant, caregiver, and the neighborhood environment&shyp;it was hypothesized that both child maltreatment and prenatal exposure to AOD would be related to:

1. lower family income.
2. lower parenting scores.
3. higher scores of depressive symptoms and somatic complaints.
4. fewer social supports.

5. perinatal risk factors such as premature birth and low birth weight.
6. infant temperament.
7. developmental delays in infancy.

Other risk and protective factors not supported by the literature, but available for analysis, included mothers' history of victimization, family satisfaction, stressful life events, and satisfaction with the quality of the neighborhood. Parenting was measured using the Adult Adolescent Parenting Inventory (AAPI; Bavolek 1984).

The sample consists of 300 mothers and infants. All children must be less than 18 months of age when they enter the study. In order to control for geography and SES, all household units are located within the state child protective services (CPS) Northern District boundaries for Chicago and have household income below federal poverty thresholds. Mothers and infants are recruited into one of three sub-samples:

1. Maltreated with Clinical Interventions: Subjects with at least one substantiated report of child abuse or neglect within the family household in the past twelve months. Subjects were identified for the study by social service agencies after referral for long-term (three to 18 months), relational based clinical interventions such as supportive counseling or psychotherapy.
2. Maltreated with State CPS Interventions: Subjects with at least one substantiated report of child abuse or neglect within the family household in the past twelve months. Subjects were identified for the study by state CPS workers from the Northern District Office for Chicago.
3. Non-Maltreated, No Interventions: Subjects with no substantiated reports of child abuse or neglect within the family household in the past twelve months. Subjects were identified for the study by local, community-based health and social service agencies.

Return to Top

Results

The following analysis was conducted on 267 mothers and infants. There were significant differences between the three sub-samples in annual family income as seen in Table 1. Defined as family income less than $5,000 per year, 33.8% of the entire sample was "super poor." The proportion of super poor families across sub-samples and between mothers with infants prenatally exposed to AOD compared to mothers whose infants were not exposed was similar. However, more mothers with infants prenatally exposed to AOD were living on AFDC compared to mothers whose infants were not exposed (see Table 2).

There were no differences between maltreating mothers and neighborhood controls in any of the AAPI domains: inappropriate expectations of children, empathy, attitudes toward the use of corporal punishment, or family role reversal. No differences were discovered in the parenting scores of mothers with children prenatally exposed to AOD compared to mothers whose children were not.

Neither maltreatment nor AOD predicted differences in depressive symptoms as measured by the Center for Epidemiological Studies - Depression Scale (Radloff 1977) or differences in somatic complaints as measured by the Health Opinion Survey (Macmillan 1957). However, as measured by the CAGE (King 1986), mothers with children prenatally exposed to AOD scored significantly higher for risk of alcoholism compared to mothers whose infants were not exposed.

Social supports were measured using the Duke-UNC Functional Social Support Questionnaire (Broadhead, Gehlbach, Degruy & Kaplan, 1988). Mothers in sub-sample 1, maltreated with clinical interventions, reported fewer social supports than mothers in the CPS sub-sample or the neighborhood controls. AOD was not related to social supports.

Of the entire sample, 22.6% were reported by mothers to have been born prematurely (less than 37 weeks gestation), 21.5% were low birth weight, and 16.3% required oxygen at birth&shyp;however none of these risk factors were related to maltreatment or prenatal exposure to AOD.

Neither maltreatment nor AOD were related to infant temperament as measured by the Infant Characteristics Questionnaire (Bates, 1980).

Infant development was measured using the Battelle Screener (Newborg, Stock, Wnek, Guidubaldi & Svinicki, 1984). Battelle Screener results include scores that represent standard deviations from the mean of the normal population. Of the total Capella sample, 21.1% scored at least one standard deviation below normal while 7% scored two standard deviation units below normal indicating serious developmental delays. There were no significant differences between the three sub-samples, but developmental delays were found in all three, including the neighborhood controls.

Using logistic regression, of all the domains reported in this analysis, only low birth weight predicted risk of developmental delays. Low birth weight infants were twice as likely to be developmentally delayed as normal weight infants. A series of interactions were also tested, e.g. low birth weight and child maltreatment, low birth weight and AOD, low birth weight and premature birth, but only low birth weight predicted developmental delays.

Family satisfaction, stressful life events, and satisfaction with the quality of the neighborhood were not related to child maltreatment or prenatal exposure to AOD.

Although history of victimization was not related to child maltreatment, mothers whose infants were prenatally exposed to AOD were significantly more likely to report that, as children or teenagers, they were either hit, slapped, shaken, or burned by a parent or someone else and that, prior to age 13, someone had tried or succeeded in having sexual intercourse with them, compared to mothers whose children were not exposed.

Return to Top

Discussion

Although some linkages between child maltreatment and AOD have been established in the literature (Curtis & McCullough, 1993; Famularo, Kinscherff, & Fenton,1993), neither child maltreatment nor prenatal exposure to AOD were related to several perinatal risk factors, infant characteristics, or observable developmental delays in infancy. No relationships were discovered between AOD and parenting practices, maternal depression, somatic complains, or infant temperament. No interactions between AOD, poverty, and infant development were uncovered.

However, several risk factors related to prenatal exposure to AOD were discovered among the mothers. Mothers with infants prenatally exposed to AOD were, by self-report, at greater risk of alcoholism and consistently reported a greater history of personal violence than mothers whose infants were not exposed.

Return to Top

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Return to Top

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Return to Top

Note: the project is funded by the Administration on Children,
Youth and Families, National Center on Child Abuse and Neglect (90-CA-1466).

[Home] [Search] [Index]

Table 1

Return to Article

Table 1
Mothers and Infants in the Capella Project by Sub-Sample
(N = 267)

	1 Maltreated with Clinical Interventions n = 63	2 Maltreated with CPS Interventions Only n = 95	3 Neighborhood Controls n = 109	Total N = 267
Age of the Mother	26.4 years	25.9 years	22.7 years	24.7 years **
Percent Minority	77.9%	74.7%	75.2%	75.7%
Percent Completed High School	36.7%	28.4%	32.2%	31.8%
Family Income	$9,667	$8,351	$11,745	$10,038 *
Percent Super Poor (< $5000 per year)	31.7%	38.3%	31.1%	33.8% *
Age of the Infants	8.4 months	7.7 months	9.0 months	8.4 months
Percent Infants Female	50.0%	51.1%	54.2%	52.1%
Percent Premature Births (< 37 weeks gestation)	28.8%	22.6%	19.3%	22.6%
Percent Low Birth Weight	23.0%	19.4%	22.4%	21.5%
Percent Delayed Development	16.4%	20.9%	24.0%	21.1%

*$p < .05$, **$p < .01$

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Table 2

Return to Article

Table 2
Mothers and Infants in the Capella Project by Prenatal Exposure to AOD
(*N* = 267)

	Prenatal Exposure to AOD *N* = 65	No Known Prenatal Exposure to AOD *N* = 202	Total *N* = 26
Age of the Mother	279 years	236 years	247 years
Mother Receives AFDC	877%	765%	793% *
Risk of Alcoholism	81	.43	52 **
Percent Premature Births (< 37 weeks gestation)	230%	225%	226%
Percent Low Birth Weight	206%	217%	215%
Percent Delayed Development	180%	22.1%	21.1%

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies,
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Evaluation of the Total Family Strategy Program

Author

Introduction Method Results
Return to Table of Contents

Introduction

The Total Family Strategy program (TFS) funded by the Juvenile Welfare Board of Pinellas County provides early intervention services to at-risk families in Pinellas County. The program is designed to prevent and ameliorate costly social problems through family empowerment, competency building, and counseling.

The program is centered on an empowerment and competency based model. This model is founded on a belief in the inherent strengths and abilities of family members. The model focuses on enabling families to identify resources in their own family and the community to resolve their problems. To help families accomplish their goals, the TFS program offers individualized services to all members of a family. Services may include in-depth assessments, case management, counseling, family therapy, parent skill building, job training, mental health, aftercare, follow-up services, and temporary financial assistance.

This program is provided by four agencies in Pinellas County. These agencies have the responsibility for organizing their program and hiring and supervising the case workers and supervisors who provide services. The agencies work with the Juvenile Welfare Board to ensure that staff are appropriately trained in the principles of family empowerment and family based service.
Return to Top

Method

Participants

A total of 181 families who were referred by social service agencies, schools or self-referrals were admitted to the program. Eligible families, as determined by a risk factor checklist, typically have low incomes, are usually headed by a single parent, and have histories of poor coping, domestic violence, alcohol, or substance abuse. Thirty-eight percent of the families served by the program received their primary income from AFDC, and 79% had a total income of less than $1,000 per month. Among the 388 children served by the program, 69% were in families of two or more children with 72% of the children under the age of seven. Presenting problems for families in the program included defiance and problems at home and school on the part of the children, and lack of parenting skills on the part of the parents.

Procedures

The evaluation of the Total Family Strategy program (TFS) was conducted through the collection and analysis of qualitative and quantitative information. Case workers collected information using the following instruments: (a) demographic face sheet; (b) a risk factor checklist which defined the eligibility of the family for the TFS program; (c) a subset of the Child Well Being Scales and the Family Risk Scales; (d) pre and post-intervention summaries which detailed specific and unique goals, expectations, and accomplishments identified and defined by family members and the case workers.

Information was also obtained from family members regarding their attitudes and expectations toward the TFS program. Qualitative data were obtained from family members participating in the program through the use of focus groups and personal interviews. To help assess change over time, quantitative data were collected when the family entered the TFS program and at six month intervals. Qualitative interviews and focus groups were conducted at the end of the evaluation period.

Return to Top

Results and Implications

Results from quantitative assessments through comparisons of pre- and post family data indicate improvement in broad areas of family stability and parenting. Repeated measures MANOVAs of case managers' ratings of family well being and t-tests of rating changes over time are provided in Table 1 and Table 2. These results were confirmed in focus groups and case interviews with family members. More stable family functioning was reflected in significant improvement in the quality of life for families and in the security of residence. The money management skills of family members were also significantly improved.

A consistent finding of qualitative data collection efforts was the degree to which the TFS program empowered and valued parents as part of the treatment process, provided a broad range of specific services to address unique family needs, gave flexible financial assistance, and was positively experienced by the program participants. One of the most consistent concerns identified was the negative impact of case worker turnover for some families, and the need for more targeted counseling services for children.

The evaluation of the Total Family Strategy program emphasized multiple sources of data to test the appropriateness and accomplishments of the program. A wide variety of problems identified for families, such as housing, employment, education, parenting skills, children's behaviors, and schooling were confirmed in family and focus group interviews. The TFS services placed value and emphasis on flexible financial support, in home counseling, and a variety of assistance for parents and children. Results of the qualitative and quantitative research indicate the strongest effects appear to be associated with improvements in the functioning of parents as care-givers. Parents have benefited both from parent-skills training and related services as well as from the reassurance, support, and hope case workers offer. The overall effect of the program in improving the quality of the participants' lives was reflected in focus group and parent interviews. Parents and case workers agree that there has been a significant improvement in the families quality of life.

Future evaluation and program reviews may focus specifically on issues related to program effects for children, long term impact on families who have graduated from active care, and a comparison of the effectiveness of the TFS program to alternative service interventions.

Return to Top

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Return to Top

[Home] [Search] [Index]

Table 1

Return to Article

Table 1
Family & Child Assessment Results

Scale	Pre-intervention	6 month follow-up	12 month follow-up	Significance
Security of residence	2.02	1.61	1.27	F(2,80)=8.78**
Availability of utilities	1.25	1.30	1.10	F(2,78)=1.42
Parental capacity for child care	1.54	1.27	1.32	F(2,80)=3.30*
Mental health care	2.03	1.50	1.47	F(2,66)=5.21**
Money management	1.63	1.44	1.29	F(2,80)=3.97*
Parental motivation to solve problems	1.67	1.50	1.50	F(2,82)=.89
Parental cooperation with case planning	1.48	1.48	1.43	F(2,82)=.11
Support for principal caretaker	2.52	1.74	1.64	F(2,82)=10.10**
Availability / accessibility of services	1.93	1.40	1.33	F(2,78)=13.83**
Parental acceptance of/ affection for children	1.81	1.53	1.46	F(2,80)=3.88*
Parental expectations of children	2.24	1.73	1.51	F(2,80)=16.65**
Parental consistency of discipline	2.25	2.00	1.83	F(2,78)=4.91*
Child family relations	2.05	1.63	1.45	F(2,78)=12.18**
Coping behavior of children	2.45	2.45	2.38	F(2,78)=.14
Adult relationships	2.32	2.14	1.75	F(2,54)=5.12**
School adjustment	2.79	2.04	1.61	F(2,54)=8.96**
Home related behavior	1.97	1.67	1.33	F(2,76)=13.45**

(* p < .05, ** p < .01)

Note: Results are average rating

[Home] [Search] [Index]

Table 2

Return to Article

Table 2
Follow-up Comparisons

	Pre and 6 Month Comparisons				Pre and 12 Month Comparisons			
	X_{pre}	X_{6m}	*df*	t Value	X_{pre}	X_{12m}	*df*	t Value
Employment	1.55	1.58	64	0.70	1.65	1.51	36	1.71
Weekly working hours	20.20	31.9	45	*2.61	21.24	30.62	20	1.65
Satisfaction with job	2.85	2.48	36	1.22	2.69	2.23	12	0.94
Stress on job	4.54	3.41	36	*2.44	2.92	3.07	13	0.50
Income sufficiency	3.65	2.84	61	**3.09	3.66	2.59	31	*2.85
Quality of home life	2.62	2.54	67	0.41	2.70	2.08	36	*2.66
Satisfaction with the relation with family member	2.52	2.38	62	0.90	2.46	2.63	34	0.88
Satisfaction with the relation with children	2.33	2.07	66	1.70	2.14	1.97	35	0.64
Getting around the community	2.22	2.07	65	1.00	2.49	2.08	36	1.49
Satisfaction with the day care services	3.19	1.56	31	**3.19	3.95	1.60	19	**2.86
Child's school problems	2.70	2.40	56	1.43	2.48	2.03	28	1.66
Behavior problems	3.12	2.79	66	2.29	2.73	2.51	36	1.28

Note: * $p<.05$ ** $p<.01$

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

The Public Mental Health and Head Start Partnership in the Ventura County System of Care

Authors

Introduction Discussion References
Return to Table of Contents

Introduction

Since 1985, the Ventura County system of care has served a defined group of children and adolescents for whom local public agencies have a mandated responsibility, viz., court wards, court dependents, and special education students who are at risk for out-of-home placement. Although they represent the most significant cost for public agencies, these youngsters represent a fraction of those with subthreshold problems (Costello & Shugart, 1992), who, if not served or underserved, could eventually require more intensive and costly services such as hospitalization and residential treatment. This paper describes work in progress whose long-term goal is to link local early childhood efforts with the existing system of care and, by doing so, broaden the target group served by the system. An important part of this effort is a developing partnership between the Ventura County Mental Health Department (VCMH) and Child Development Resources of Ventura County (CDR), administrator of the countywide Head Start program. This collaboration seeks to improve services to at-risk children who are younger and demonstrate less impairment than the current target population but who could eventually become involved with local public agencies.

Local Head Start Program

Program Structure and Services

Organization of the local Head Start program reflects goals and service requirements set forth in federal performance standards (U.S. Department of Health and Human Services [DHHS], Administration for Children, Youth and Families, 1992; 1993). The program offers center- and home-based options. Most children participate in the center-based program which includes 49 part-day classes (i.e., 3.5 hours per day, 5 days per week) at 17 centers throughout the county. Classes are staffed by a teacher, teacher aide and parent volunteer(s). Average class size is 18.5. A family service specialist (FSS) is also assigned to each center. The average FSS caseload is 60.

The home-based option includes five home-based groups each comprised of a teacher and 12 children. Teachers visit each child at home once a week for a 90-minute session and supervise two group events each month. Unlike the center option where a FSS provides family support, the home teacher initiates all family services.

Enrolled children and families receive services in five program areas: education (regular and special education), health (medical, dental, and mental health), nutrition (provide part of child's daily nutritional needs and parent education), parent involvement (parent education and participation in program planning/operation), and social services (family needs assessment, referral, and community outreach).

Population Served

Data from the Head Start Program Information Report (PIR) for 1993-94 reveal that the local program enrolled 1,167 children from 1,062 families (funded enrollment for the year was 966 children). This group included nearly twice as many 4-year-olds (746; 63.9%) as 3-year olds (421; 36.1%) and nearly the same number of males (582; 49.9%) and females (585; 50.1%).

The data also suggest the importance of cultural, economic, and mobility issues in serving this population. For example, the children were predominantly Hispanic with the proportions of enrolled Caucasian and Hispanic children differing markedly from the distribution of ethnicity found in the general county population (see Table 1). Furthermore, 774 (66.3%) of the children were enrolled in Medicaid/EPSDT and 1,007 (94.8%) of the families had incomes at or below federal poverty guidelines. Finally, the PIR shows that 258 (34.6%) of the 4-year-olds had been enrolled during the previous year and that 196 (16.8%) of the children enrolled in 1993-94 dropped out after classes began during the year. Although the number of 3-year-olds enrolled in 1992-93 and the number of 4-year-olds in the 1993-94 program year who were enrolled in Head Start outside the local program are unknown, the data suggest that a number of children do not enroll for a second year.

Data obtained on 695 families at the beginning of the current 1994-95 program year indicate the presence of other risk factors. These include the numbers of single-parent families (301; 44.3%), families in which mother (521/672; 77.5%) or father (122/385; 31.7%) is unemployed, families in which mother (350/670; 52.2%) or father (217/386; 56.2%) is not a high-school graduate, and families indicating a need for social services (884; 83.2% of family needs assessments completed).

Special-Needs Population

Federal performance standards (DHHS, Administration for Children, Youth and Families, 1993) specify that at least 10 percent of a program's funded enrollment be allocated to serve children with a professionally diagnosed disability and that such children receive services in accordance with an individual education plan (IEP). Of children enrolled locally in 1993-94, 112 (9.6%) had a professionally diagnosed primary disability. By far, speech/language impairment (73; 65.2% of diagnoses) was the most common disability (see Table 2). In contrast, only 3 children were diagnosed with emotional/behavioral disorder (2.7 % of diagnoses or 0.3% of enrolled children).
A concern is that the small number of emotional/behavior disorder cases identified may reflect assessment that uses a clinical approach that is too narrowly focused and that lacks an appropriate developmental perspective (Forness & Finn, 1993). Alternatively, assessment may need to focus on defining impairment in child functioning and identifying absence of family and community supports.

Program Linkage

Basis for Collaboration

Based on their shared interest in early inter-vention with young children, Ventura County Mental Health and Child Development Resources began a partnership to serve children in Head Start. The agreement was approved by the County Board of Supervisors and called for VCMH to dedicate a full-time psychiatric social worker to serve as mental health consultant to the Head Start program for the 1994-95 program year. Since the social worker delivers services in accordance with federal performance standards for meeting the mental health needs of Head Start participants, the agreement was timely given recent recommendations for strengthening services to enrolled children (Piotrkowski, Collins, Knitzer, & Robinson, 1994). Also, the agreement allowed CDR funds that were designated for mental health consultation to be leveraged with VCMH Medicaid billing where medical necessity could be established.

From its perspective, VCMH is anticipating the impact of a statewide initiative to manage mental health services for Medicaid recipients. Under the plan, Medicaid funding for services to the chronically ill and for outpatient and acute care will be consolidated at the county level. In the process, state treatment dollars and the responsibility for serving all Medicaid-eligible children and their families (including most Head Start families) will shift to counties. Since funding will eventually be capped, a county can minimize the risk of exhausting its fund by developing a managed care system that minimizes expensive, out-of-home services and maximizes the effectiveness of less expensive, early intervention services like Head Start.

Head Start VCMH Consultant

The social worker provides all mental health services specified in Head Start performance standards: (a) consults with teachers and family service specialists; (b) biannually observes all children in a classroom setting; (c) assists in providing assessment, treatment, referral and case management services to referred children; and (d) works with parents to help achieve the goals of the mental health program. Wherever appropriate, service delivery is arranged to meet VCMH Medicaid billing requirements for assessment, treatment, and case management.

Referred Cases
The 31 referrals received by the social worker since implementation of the agreement have come from teachers (20; 64.5%), family specialists (7; 22.6%), public health clinics (3; 9.7%), and parents (1; 3.2%). Three centers with a total enrollment of 156 referred no children and one center with an enrollment of 40 referred 4 (10%) children. More of the referred children were male (17; 54.8%) and most were Hispanic (21; 67.7%), 4 and 5 years-old (26; 83.9%) and Medicaid-eligible (21/30; 70.0%). Presenting problems most frequently identified by the referral source were emotional/behavior problems (12; 38.7%), parent concerns (6; 19.4%), and family problems (5; 16.1%). It is noteworthy that none of the referred children could be given a DSM Axis I primary diagnosis and only one could be given a diagnosis on Axis 2.

Important family characteristics of referred children are reflected in the numbers of single-parent families (16;, 51.6%), families without a wage-earner (14/30; 46.7%), AFDC-eligible families (21/28; 75.0%) and families previously investigated by child protective services (8/28; 28.6%). Spanish was the primary language in the home for 7 (22.6%) of the children and 7 (22.6%) resided in homes that were bilingual.

These results raise a number of key issues. First, the referral process must be developed to insure that the consultant serves those children who are most in need. Important steps here include: (a) developing explicit guidelines for referral; (b) training staff in these guidelines; and (c) encouraging parent participation in the referral process so that problems in non-school settings are identified. Second, revenue has not been generated as expected since none of the 31 referred children met the medical necessity criteria for mental health services under Medicaid. While these children continued to receive services from the social worker beyond the 60-day period for determining medical necessity, an important element in the partnership has not been realized so far. This result indicates the need to learn more about the mental health and other needs of this population and to arrange service delivery in a way that satisfies the respective priorities of Head Start agencies and public mental health.

Return to Top

Implications

Early intervention seeks to build upon the network of resources that support a child's growth at earlier points in the developmental process. As a practical matter, introducing early intervention in an existing system of care whose services constitute tertiary prevention requires a significant expansion in focus. In particular, criteria for a broader target population must be developed (Jordan & Hernandez, 1990) since few children in early childhood programs such as Head Start meet the criteria for the current target population (i.e., psychiatric diagnosis, significant functional impairment, and out-of-home placement risk). The expanded criteria may well include critical events that reflect early public agency involvement, age-appropriate norms for functional impairment, and the absence of key family and community supports.

New outcomes and services must also be developed and integrated within the existing system. Change resulting from this process must be seen as a systematic extension of the deep-end of the system toward its shallow-end, rather than as an unrelated patch. Indeed, as change is introduced, the enhanced system must continue to monitor and manage outcomes for its population with SED (e.g., out-of-home placement) since it is the avoidance of the cost of deep-end services that assures funding for the early identification and community-based treatment.

Achieving these goals will require a research agenda which includes various tasks: (a) develop a management information system that provides easily retrievable data on child and family characteristics, referrals made, services delivered, and outcomes obtained; (b) develop and test a developmentally appropriate model for identifying children with serious functional impairments; (c) develop a set of outcomes to be assessed annually (e.g., increase the number of children who return from the previous year's enrollment and reduce the number of children who leave the program during the year); and (d) develop a model for transitioning children from Head Start to elementary school programs and tracking of their subsequent involvement with public services over time.

Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

Table 1

Return to Article

Table 1
Ethnicity for Children Enrolled in Ventura County
Head Start in 1993-94
(n = 1167)

Ethnicity	n	% of County Enrollment	% of Total Population
Caucasian	186	15.9	65.9
Hispanic	890	76.3	26.4
Asian/Pacific Islander	23	2.0	4.9
African American	57	4.9	2.2
Native American	11	0.9	0.5

[Home] [Search] [Index]

Table 2

Return to Article

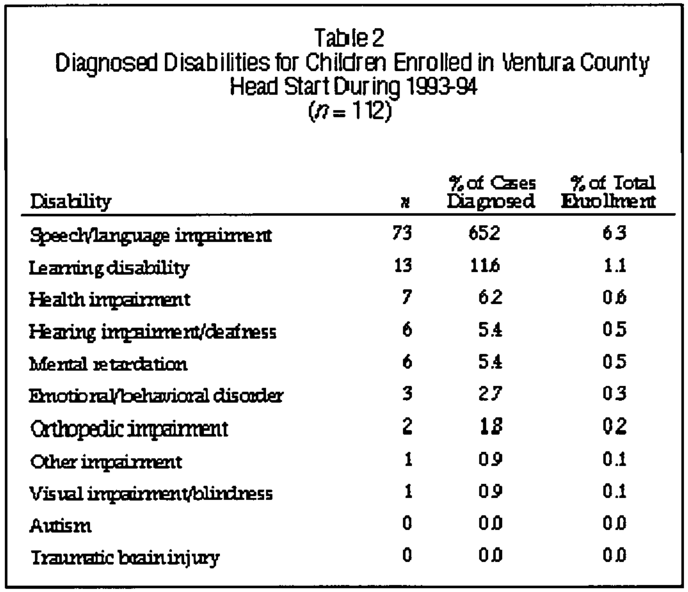

Table 2
Diagnosed Disabilities for Children Enrolled in Ventura County Head Start During 1993-94
(*n* = 112)

Disability	*n*	% of Cases Diagnosed	% of Total Enrollment
Speech/language impairment	73	65.2	6.3
Learning disability	13	11.6	1.1
Health impairment	7	6.2	0.6
Hearing impairment/deafness	6	5.4	0.5
Mental retardation	6	5.4	0.5
Emotional/behavioral disorder	3	2.7	0.3
Orthopedic impairment	2	1.8	0.2
Other impairment	1	0.9	0.1
Visual impairment/blindness	1	0.9	0.1
Autism	0	0.0	0.0
Traumatic brain injury	0	0.0	0.0

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies,
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Parental Agreement on Ratings of Child Behavior: Measures of Agreement and Related Factors

Authors

Introduction Method Results Discussion References
Back to Table of Contents

Introduction

The purpose of the present study was twofold. The first objective was to compare three common measures of agreement in describing child behavior problems. Pearson correlations, Cohen's kappa, and percent agreement calculated from the data were compared in order to examine characteristics of each measure in describing interinformant agreement for ratings of child behavior. Researchers have calculated agreement differently thus complicating comparison across studies. Some of the putative measures of agreement suffer from flaws that are not recognized or acknowledged (e.g., Bartko & Carpenter, 1976), and researchers often make assumptions about the appropriateness of measures with little rationale (e.g., Berry & Mielke, 1988). The blind use of an analytical tool without acknowledgment of its shortcomings and appropriateness for measuring the construct of agreement in a specific situation may produce results that are misleading as to the actual degree of agreement between informants.

Typically, agreement has been expressed using product-moment correlations of standardized summary scores across pairs of informants (Achenbach, McConaughy, & Howell, 1987; Eisenstadt, McElreath, Eyeberg, & McNeil, 1994) or correlations across items for pairs of informants (Achenbach, 1991; Fischer, Barkley, Fletcher, & Smallish, 1993). Although correlations reflect relative association between informants, they are not appropriate indices of interinformant agreement (Bird, Gould, & Staghezza, 1992). Correlations reflect only the association between groups of items and not absolute agreement between raters. It is possible to obtain a high degree of association (correlation) yet little agreement within the pair (Jensen, Traylor, Xenakis, & Davis, 1988). The pattern of responses within a pair of informants may be almost identical yet be anchored at different points on a scale.

An alternative index of agreement is kappa, first proposed by Cohen (1960), which assesses the proportion of agreement after removing the effects attributable to chance. It too has been criticized. Not only is the statistic tedious to compute, its values vary with factors other than agreement, specifically sensitivity, specificity, and the prevalence or base rate of the target illness or behavior. Several researchers have acknowledged some of these problems (Brennan & Hays, 1992; Feingold, 1992; Hutchinson, 1993; Maclure & Willett, 1987) including Spitznagel and Helzer (1985) who noted that the problems caused difficulty in comparing kappa values across studies. Even so, researchers have not adequately recognized and addressed the impact of varying base rates on kappa within studies.

Finally, an expression of interinformant agreement that avoids the problems that plague kappa and correlation is percent agreement. Percent agreement is relatively easy to calculate, and researchers and practitioners alike comprehend its meaning. Recently, more researchers investigating interinformant agreement of child behavior ratings have utilized percent agreement as the descriptor of choice (Kaslow, Warner, John, & Brown, 1992; Kolko & Kazdin, 1993; Renouf & Kovacs, 1994). Although the statistic does not account for chance agreement, the argument is made here that when considering agreement between experts' ratings, chance agreement is inconsequential. The rationale needs to presented for making deductions rather than vice versa.

The second objective of this study was to examine several child, parent, and dyadic-level variables for significant correlations with mother/father agreement about their child's behavior. Particular emphasis was placed on looking at dyadic-level variables that have received scant attention in the literature relative to individual-level variables such as gender and child age.

Return to Top

Method

Participants were children and their families who were referred to a pediatric clinic for assessment of common behavioral concerns and for whom Child Behavior Checklist (CBCL; Achenbach, 1991) data were available from both parents. Sixty children, 46 males and 14 females, ranging in age from 4 to 12 years (M = 6.7, SD = 2.05), comprised the sample. Ninety percent of the sample was Caucasian. All lived with two parents, 80% with both biological parents while the remaining children's parents were divorced and remarried. Finally, participants represented a wide range of socioeconomic levels. In addition to the CBCL, parents completed a variety of measures including the Duncan Socioeconomic Index (Duncan, 1961), the Mental Health Inventory (MHI; Veit & Ware, 1983), the Dyadic Adjustment Scale (DAS; Spanier, 1976), and the Life Experiences Survey (SLES; Sarason, Johnson, & Siegal, 1978).

Return to Top

Results

Measures of Agreement

Figure 1 demonstrates that, given the same number of disagreements, kappa values, and to a lesser extent correlations, decreased with higher mother/father pair base rates, or more agreement that the behaviors did not describe their child. For children who exhibit few problem behaviors, parents are more likely to have relatively more response combinations in one cell (0,0 for the CBCL). Because of kappa's calculation and definition of chance, when parents agreed that a substantial number of items did not characterize the behavior of their child, a larger deduction in the pair's kappa value was made to account for chance, thereby reducing the observed kappa value. Thus, over pairs, there is greater variance in the measure resulting from factors not related to agreement. When used as a dependent measure, the increase within measure variance of kappa and correlations due to marginal symmetry and higher base rates make them far less sensitive to the independent variables. In addition to Figure 1, this fact also is demonstrated in the tables by fewer significant findings when using kappa or correlations as a measure of agreement.

We recommend using percent agreement as a measure of agreement between respondents when they are providing judgments about which they can be considered an expert, and particularly when one response category might be more frequently used. Percent agreement is easier to calculate and understand conceptually than are other measures of agreement. As mentioned above, it also can be more powerful if other measures suffer from large within-measure variance.

One criticism of percent agreement as a measure of agreement is that it does not account for agreement due to chance. However, we assert that chance has very little impact in observed agreement when respondents are asked to make judgments about which they can be considered experts. Parents make expert judgments about their children's behavior over time. Thus, the similarity between informants' responses results almost solely from similar perceptions rather than from chance.

Factors Related to Mother/Father Agreement

Average agreement between mothers and fathers was high, 73.5% (SD = .10, range 40.7% - 94.8%). Percent agreement correlated with several child and parent characteristics including mothers' and fathers' levels of psychological distress, general well-being, and reported recent positive life events. Agreement also was negatively related to fathers' reported negative life events and positively related to mothers' reported SES.

Dyadic psychological distress and general well-being were significantly correlated with agreement. Couples with more distress showed less agree-ment, and couples with higher well-being scores showed more agreement. Mother/father agreement on their children's behavior was negatively correlated with discrepancy scores for marital satisfaction, affection, consensus, and negative life events. Our findings emphasize the need to look at dyadic- and family-level variables in addition to individual characteristics. Please refer to Table 1 and Table 2 for significant correlations between agreement and individual and dyadic-level variables. (Although percent agreement is supported here as the index of choice, results using kappa and correlations are retained for illustrative purposes as well as to compare to other studies.)

Return to Top

Implications

On average, we found a high degree of agree-ment between parents when reporting on their children's behavior. This finding is important in relation to screening. Because of the similarity in mothers' and fathers' reports, screening can be undertaken using the report of only one parent. However, once a child is identified or when a more in-depth assessment is made, information should be collected from both parents to provide a more complete picture of the child and family context. Additionally, our findings emphasize the need to look at dyadic- and family-level variables in addition to individual characteristics.

In the future, more research should investigate the outcomes of agreement. For example, do children whose parents exhibit higher agreement demonstrate better outcomes? Is higher mother/father agreement related to treatment compliance or remaining in treatment? An interesting finding of this study was that the number of disagreements about the presence/absence of a behavior was more than twice the number of disagreements about the frequency of a behavior. Future research should investigate the hypothesis that better outcomes would be exhibited by children whose parents disagreed more about the frequency of behaviors than about the presence/absence of behaviors.

Return to Top

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Return to Top

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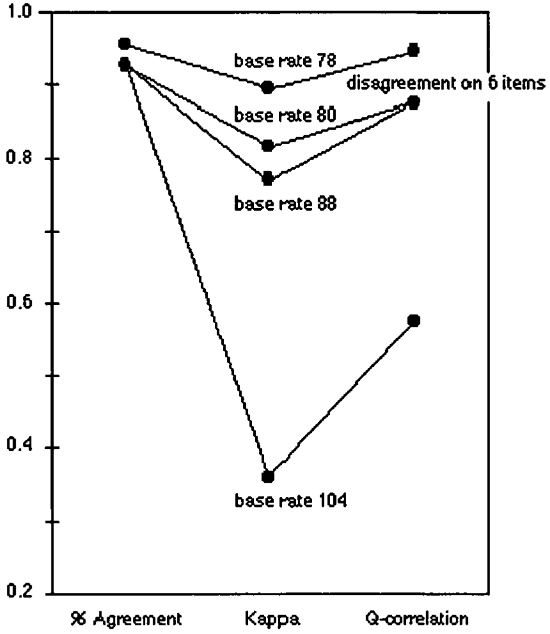
Return to Top

Figure 1

Return to Article

Figure 1
Disagreement on 9 Items (unless noted)



[Home] [Search] [Index]

Table 1

Return to Article

Significant Correlations between Child and Parent Characteristics & Alternative Dependent Measure

	Percent Agreement	Kappa	Correlation
Child age (*n*=60)			
SES-mother (*n*=55)	23*	27**	29**
SES-father (*n*=53)			
Mothers' DAS (*n*=56)			
satisfaction	26*		
cohesion			
consensus			
affection			
Fathers' DAS (*n*=53)			
satisfaction			
cohesion			
consensus			
affection			
Mothers' MHI (*n*=57)			
distress	-40***		
well-being	33**	23*	
Fathers' MHI (*n*=57)			
distress	-28**		
well-being	33**	23*	
Mothers' SLES (*n*=57)			
negative			
positive	27**		
Fathers' SLES (*n*=52)			
negative	-36***		
positive	24*		

Note. $^{*}p<.10$. $^{**}p<.05$. $^{***}p<.01$.

[Home] [Search] [Index]

Table 2

Return to Article

Significant Correlations between Dyadic-level Variables and Alternative Dependent Measures

	Percent Agreement	Kappa	Correlation
Combined scores (mother's + father's)			
MHI (*n*=56)			
dyadic distress	$-.41^{***}$		
dyadic well-being	39^{***}	27^{**}	
Difference scores (abs of mother's - father's)			
DAS (*n*=51)			
satisfaction	-26^{*}	-29^{**}	-28^{**}
cohesion			
consensus	-24^{*}	-24^{*}	30^{**}
affection	-31^{**}	-24^{*}	
SLES (*n*=48)			
negative	-25^{*}		
positive			

Note. $^{*}p<.10.$ $^{**}p<.05.$ $^{***}p<.01.$

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies,
Florida Mental Health Institute, University of South Florida,1996

CAFAS as a Measure of Child and Family Functioning Among Children and Families Enrolled in Intensive Case Management in New York State

Author
Introduction Method Results Discussion References
Back to Table of Contents

Introduction & Method

Intensive Case Management (ICM) for children is New York State's most intensive, home-based service option within its community based system of care. Intensive case managers are available to children and families at all times and serve a small caseload of ten children and families. They perform a comprehensive assessment of family and child needs and link families to needed services. Work with children and families is done in settings outside of the office and providers are expected to actively advocate for enhanced service delivery for children and families and system change. In addition, flexible service dollars are available for the purchase of services otherwise unavailable.

In evaluating outcomes for children enrolled in ICM, researchers at the Bureau of Evaluation and Services Research of the New York State Office of Mental Health conducted a longitudinal study of a sample of 199 children enrolled in the program. On average, children in the sample were 11 years of age, white, non-Hispanic, mostly male, primarily lived in single parent households, were in the custody of a biological parent, and went to school in a special education setting. The most common diagnosis among these children was disruptive behavior disorder. They were out of home (either hospitalized or in out-of-home placement) an average of two times prior to enrollment, were functionally impaired in an average of 2.5 out of 5 areas, and displayed an average of 5.5 problem behaviors or symptoms (out of 25).

The study included a number of measures to describe the status of children and families enrolled in the program. To measure functioning status of both children and families, the Child and Adolescent Functional Assessment Scales (CAFAS; Hodges, 1990) was administered at enrollment and at three years or discharge. In addition to CAFAS scales, child status was also measured using a yes/no checklist of five areas of functional impairment, a yes/no checklist of presence of 25 behaviors and symptoms, and from the parent perspective, the Child Behavior Checklist (Achenbach, 1991). Additional measures of family status were an assessment of family problem conditions, evidence of abuse in the family's history, and six selected scales from the Child Well-Being Scales (Magura & Moses, 1986). The availability of this set of child and family functioning measures allowed for an examination of the validity of the CAFAS measure for this population of children with serious emotional disturbances and their families.

A factor analysis of the CAFAS scales produced two discrete factors. The CAFAS subscales fell cleanly into a Child Functioning factor (Child CAFAS) made up of the Role Performance, Behavior Towards Self and Others, Moods and Emotions, and Thinking subscales and a Caregiver Resources Factor (Caregiver CAFAS) made up of the two caregiver resources subscales. The Substance Abuse subscale did not load on either factor and was omitted from this investigation. These factors along with the Total CAFAS Score (omitting substance abuse) comprised the key measures that are examined by the analyses that follow.

Return to Top

Results

Family History of Abuse

Figure 1 displays the ability of CAFAS scales to discriminate between families that were reported as having evidence of various types of abuse and those that were not. For all types of abuse or neglect, the Caregiver CAFAS and Total CAFAS mean scores were significantly different for groups of families where such abuse and neglect was present, versus those that had no such evidence. In the case of sexual abuse, the Child CAFAS score was able to discriminate, as well.

Family Functioning

On measures of family problems, caregiver capacity for childcare, primary caregiver/spouse relationship, continuity of caregiving, caregiver's ability to recognize the child's problem condition and caregiver's cooperation with service provision, the Caregiver CAFAS scale significantly discriminated between groups of families that were clustered by high and low levels on each measure. The Total CAFAS significantly discriminated between groups of families that were identified with high and low levels of family problems, caregiver capacity for childcare, continuity of caregiving, and caregiver cooperation.

Areas of Functional Impairment

A yes/no checklist assessing functional impairment in five areas was administered to intensive case managers when children were enrolled in the program. The Child CAFAS and Total CAFAS scores significantly discriminated (at various levels of significance) between children identified as being impaired in the areas of self-care, cognitive functioning, and self-direction (see Figure 2). The two areas where no significant discrimination was observed have heavily skewed distributions. Almost all children were identified as impaired in the area of social relationship functioning and very few were impaired in the area of motor functioning.

In general, CAFAS measures did not dis-criminate for the presence or absence of symptoms/behaviors for this population, adding to evidence that measures of functioning and symptomatology may be independent. Only in the area of psychotic symptomatology was the Child CAFAS scale able to discriminate among children who displayed these symptoms from those who did not.

The Child CAFAS scale was able to discriminate between children who scored in the clinical range on the parent completed CBCL Total Problem, Internalizing, Externalizing scales. The Total CAFAS only discriminated on the Total Problem Score (see Figure 3).

CAFAS and ICM Outcomes

A logistic regression analytic model was used to examine the ability of CAFAS scales to discriminate between children who were hospitalized after enrollment in the program and those who remained in the community. This model successfully classified hospitalization outcomes for 87.3% of children (see Table 1). Male children with high average total CAFAS scores (20 to 30), who were referred from mental health programs, lived in non-family settings at enrollment, and had recent contact with the mental health service system, had a 72% probability of being hospitalized after enrollment in ICM. This model identified the presence of these conditions as corresponding with the greatest likelihood of hospitalization.

Shifting each measure in the model to an opposite or less severe condition, while leaving the others unchanged, decreased the probability of hospitalization and tested the strength of each measure's contribution to the prediction of a hospitalization outcome. Change in the CAFAS measure made the greatest impact on the prediction of hospitalization. A child with a low average CAFAS score (0 to 10) had a 32% probability of hospitalization when all the other measures were unchanged, a decrease in probability of 41% from a high CAFAS score. Shifting from a High CAFAS to a Medium CAFAS (10 to 20) reduced the probability only by 8%.

Return to Top

Conclusion

From the perspective of the evaluation of ICM, the correlation between the CAFAS measures and CBCL scores suggest a shared sense of children's problem severity among parents and providers. More generally, the data presented here contribute to the body of evidence that the CAFAS measure is a psychometrically valid measure of child and family functioning. Its attractiveness as a measure is further strengthened by the ease with which the scales can be successfully administered to providers and the resultant high response rate.

Return to Top

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Return to Top

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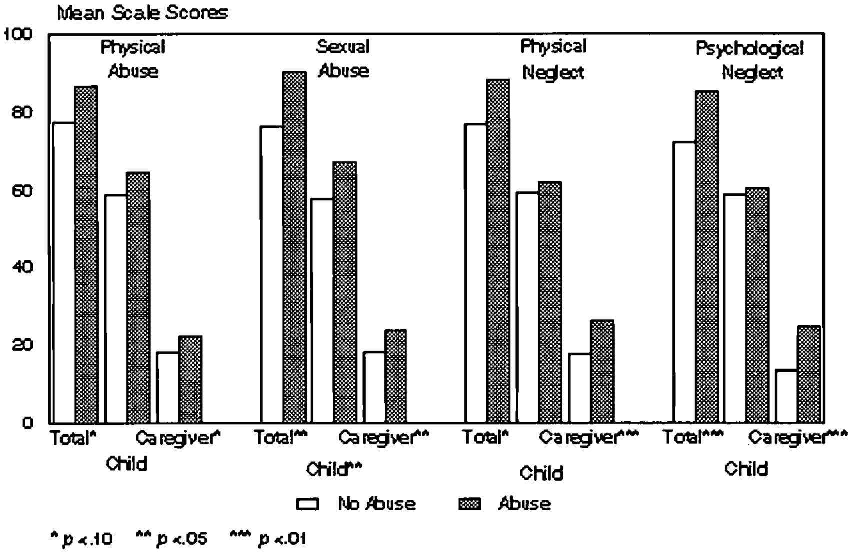
Return to Top

[Home] [Search] [Index]

Figure 1

Return to Article

Figure 1
Family History of Abuse
and CAFAS Subscales

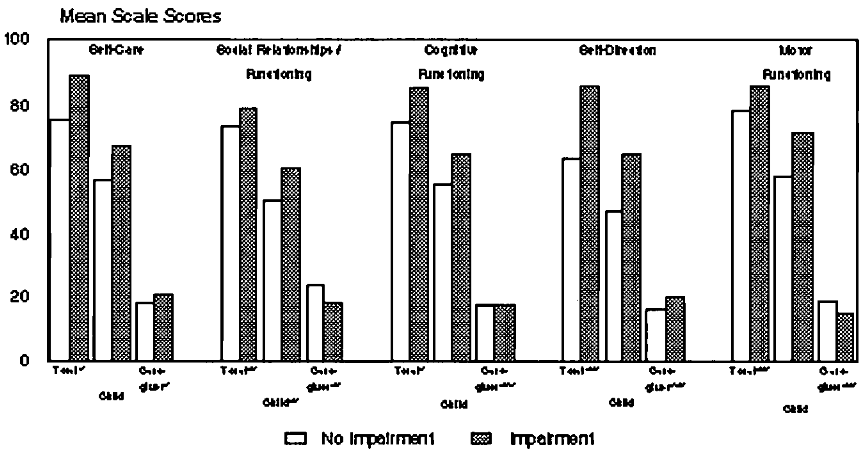


[Home] [Search] [Index]

Figure 2

Return to Article

Figure 2
Areas of Functional Impairment
& CAFAS Subscales



[Home] [Search] [Index]

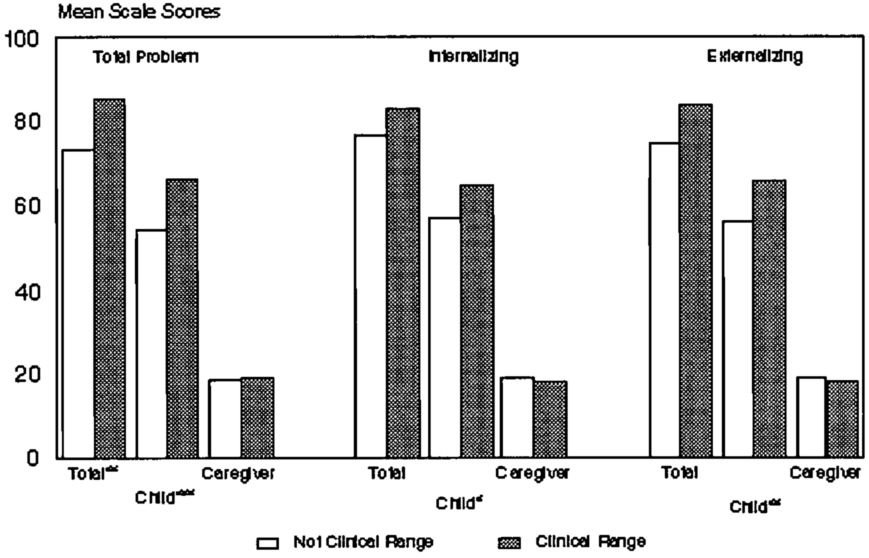
Figure 3

Return to Article

Figure 3

Child Behavior Checkless Scales

CAFAS Subscales



*p < .10 **p < .05 ***p < .01

[Home] [Search] [Index]

Table 1

Return to Article

Table 1
Post-Intensive Case Management Enrollment Hospitalization
Logistic Regression Model
(N=199)

Measure	Probability of Hospitalization	Difference	Maximum Model Probability of Hospitalization
High Total CAFAS Score *	0.3178 (Low CAFAS)	0.4061	0.7239 (High CAFAS)
Mental Health Referral *	0.3461 (No)	0.3779	0.7239 (Yes)
Living Arrangement at Enrollment *	0.3805 (Family Setting)	0.3434	0.7239 (Not Family Setting)
Gender *	0.4525 (Female)	0.2715	0.7239 (Male)
Recent Mental Health Contact *	0.4750 (No Previous Mental Health Contact)	0.2489	0.7239 (Recent Mental Health Contact)
Medium Total CAFAS Score *	0.6433 (Low CAFAS)	0.0807	0.7239 (High CAFAS)

* p<.05 Model Successfully Classifies 87.3% Cases

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

The CAFAS as an Outcome Measure in the Alternatives to Residential Treatment Study

Author
Introduction Method Results References
Back to Table of Contents

Introduction

Psychiatric nomenclature advances a multiaxial approach to psychiatric assessment emphasizing measurement of five dimensions: psychiatric symptoms, personality disorders, physical health problems, type and severity of life stressors, and global assessment of functioning. This last dimension has evaded sophisticated measurement; however, development of tools to measure global functioning is increasingly important as funding agencies include functional impairment in definitions of youths' serious emotional disturbance, and third party payers rely on severity of impairment in order to qualify persons for intensive services (Hodges & Gust, in press). Over the past several years, Kay Hodges has been developing and refining the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 1990; Hodges, Bickman, & Kurtz, 1991; Hodges & Gust, in press). The 1990 version of the CAFAS was designed to measure impairments in youths' performance of expected roles within the family, school, and community. The purpose of the present study was to evaluate internal consistency and validity of the 1990 CAFAS as well as its sensitivity to change over time.

Return to Top

Method

Procedure

The Alternatives to Residential Treatment Study (ARTS) was designed to describe five exemplary community-based alternatives to residential treatment programs1 (detail in Duchnowski, Johnson, Hall, Kutash, & Friedman, 1993). All youth entering selected programs were eligible for study recruitment if they were between 6 and 18 years of age, it was their first entry into the program, and they and their caregivers consented within one month of entry. Demographic information, history of services received, multi-dimensional psychosocial functioning, and emotional/behavioral problems were assessed. Entry into the study included baseline, 6 month, and 1 year follow-up assessments. One hundred sixty- three youth participated in the first assessment. Youth who had complete data for baseline and 12-month follow up were included in the present study (130 youth; sample attrition from initial assessment to 1 year follow-up 20.2%). There were no differences on age, race, sex, or symptom severity between those with complete longitudinal data and those without complete data.

Participants

Youth averaged 14.1 years (SD = 3.1 years). Sixty-six percent were male, 64.6% Caucasian, 12.3% African American, 12.3% Native American/Alaskan, 10.0% Latino, and one youth was Asian. At the point of entry into the programs, these youth presented emotional, behavioral, and social problems that were severe, long term, and complex (Cascardi, Kutash, & Duchnowski, 1994). Youth had received prior residential mental health services an average of 4 times, 61% of the sample had prior involvement with law enforcement and juvenile justice systems, and nearly 80% percent had received Special Education services prior to program entry. Sixty-three percent entered the programs from an out-of-home residential setting.

Measures
Baseline and 1-year follow-up data from the CAFAS, Child Behavior Checklist (CBCL; Achenbach, 1991), and Rosenberg's (1989) brief 10-item Self-Esteem Scale, and type of services used over 1 year were analyzed. The CBCL is a widely-used measure utilizing parent report of presence and severity of a variety of emotional and behavioral problems of childhood and adolescence. It yields total, internalizing, and externalizing behavior problem scores. The Self-Esteem Scale is a youth report of general self worth. The 1990 CAFAS is a brief, multi-dimensional measure of impairment in functioning, with 5 subscales each utilizing four rating categories.
Return to Top

Results & Discussion

Reliability analysis revealed the first 5 subscales of the CAFAS were internally consistent, with a Chronbach's alpha of .7122. Table 1 presents information on validity of the CAFAS. The bivariate association of CAFAS total and subscales scores, CBCL, and Self-Esteem were evaluated with Pearson product-moment correlations.

The CAFAS total score and subscales were significantly associated with CBCL scores. Deficits in youths' ability to conform their behavior to appropriate social roles was more significantly associated with externalizing than internalizing behavior problems ($z = 2.51$, $p<.05$). The magnitude of the correlations between the CAFAS and CBCL are moderate, suggesting each measures a different construct. Unexpectedly, the CAFAS and Self-Esteem measure were not significantly correlated. Sensitivity to change was measured using repeated measures analysis of variance and matched pair t-tests. There was an overall time effect for CAFAS subscales, Wilk's lambda $(5,125) = 7.94$, $p<.001$. Means, standard deviations, and significance tests are presented in Table 2.

The CAFAS Total, Role Performance, Thinking, Emotional Health, and Behavior toward Self/Others all showed statistically significant improvement from youths' entry into the program to one year post-entry. Youth in this sample also showed statistically significant improvement on the CBCL, $t(126) = 4.03$, $p<.001$, baseline = 71.80 (SD = 8.18), one year follow-up = 68.32 (SD = 10.40). Although statistically significant decreases were found on the CBCL, youth, on average, did not demonstrate clinically significant change on this scale. Importantly, the change in mean scores on the CAFAS suggests that youth demonstrated clinically meaningful change, moving from moderate toward mild impairment. Scores on Substance Use subscales did not show significant change. This was due most likely to the limited impairment in this area for the current sample.

While mean change over time suggests promise for the CAFAS's sensitivity, mean scores do not identify youth who may have shown deterioration or lack of change in functioning over time. The scaling of the CAFAS lends itself to categorical analysis so that youth showing improvement, no change, or deterioration can be identified. Such analysis indicated that 62% of youth moved to a "less impaired" category of impairment, 11% showed no improvement, and 27% further deteriorat-ed over time. Percent improvement provides additional support for the sensitivity of the CAFAS to change over time for both improvement and deterioration of functioning.

What factors account for change in CAFAS scores? It is possible that the observed change was due to regression to the mean, maturation, or effective provision of service. Since ARTS is not a contrasted group design, it is difficult to rule out maturational and regression to the mean effects. However, one can evaluate whether change (improvement versus deterioration) bears any statistical relationship to service utilization.

Caregivers were asked whether any of 50 services, from the major service sectors as well as paraprofessional support, were received at any time in the first year of treatment. These 50 services variables were collapsed into broad-ranging categories and dummy coded as: received&shyp; yes or no. Point biserial bivariate correlations were computed between CAFAS at follow-up and service domain, partialling out baseline CAFAS score. There was a significant association between improvement in Substance Use and probation services ($r = -.21$, $p<.05$) and juvenile justice residential services ($r = -.24$,

$p < .05$). This association likely is due to restricted opportunity for these youth to use illicit substances while under close supervision. A significant association also was found between deterioration in overall functioning and receipt traditional mental health residential services (including residential treatment centers, group homes, psychiatric hospital; $r = .28$, $p < .05$).
One might interpret this association several ways. It is possible that mental health residential services were not effective. Alternatively, the most severely impaired youth may have been offered these services making change more difficult to achieve.

Findings from this study suggest that the CAFAS shows promise as a sensitive outcome measure in a sample of youth with serious emotional disturbance. While it is difficult to isolate the reason for change on the CAFAS in the present study because no comparison groups were used, these findings support continued evaluation of this instrument. The statistically and clinically meaningful change observed in this sample is especially encouraging in light of studies that have shown that youth with serious emotional disturbance have relatively poor outcomes (Silver et al., 1992; Wagner, D'Amico, Marder, Newman, & Blackorby, 1991).

Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

Table 1

Return to Article

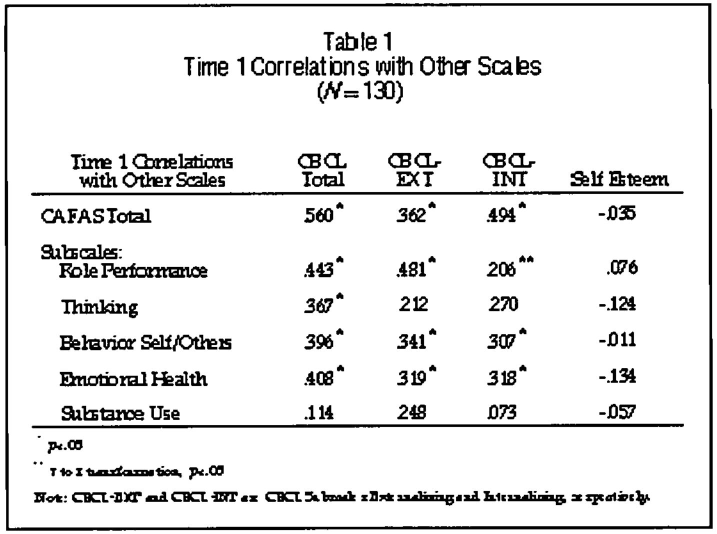

Table 1
Time 1 Correlations with Other Scales
($N = 130$)

Time 1 Correlations with Other Scales	CBCL Total	CBCL-EXT	CBCL-INT	Self Esteem
CAFAS Total	560*	362*	.494*	-.035
Subscales:				
Role Performance	.443*	.481*	206**	.076
Thinking	367*	212	270	-.124
Behavior Self/Others	396*	341*	307*	-.011
Emotional Health	.408*	319*	318*	-.134
Substance Use	.114	248	073	-.057

* $p < .05$

** r to z transformation, $p < .05$

Note: CBCL-EXT and CBCL-INT are CBCL Subscales Externalizing and Internalizing, respectively.

BEST COPY AVAILABLE

[Home] [Search] [Index]

Table 2

Return to Article

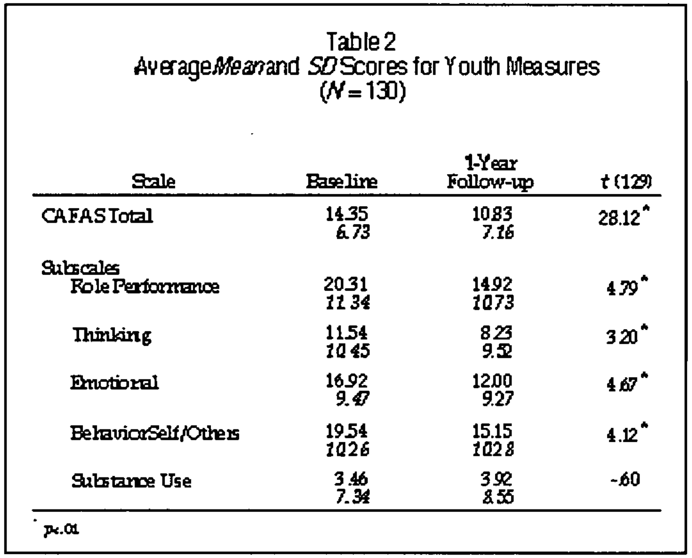

Table 2
Average *Mean* and *SD* Scores for Youth Measures
(*N* = 130)

Scale	Baseline	1-Year Follow-up	t (129)
CAFAS Total	14.35 *6.73*	10.83 *7.16*	28.12*
Subscales			
Role Performance	20.31 *11.34*	14.92 *10.73*	4.79*
Thinking	11.54 *10.45*	8.23 *9.52*	3.20*
Emotional	16.92 *9.47*	12.00 *9.27*	4.67*
Behavior Self/Others	19.54 *10.26*	15.15 *10.28*	4.12*
Substance Use	3.46 *7.34*	3.92 *8.55*	-.60

* $p < .01$

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

An Innovative Methodology for Assessing Children's Mental Health Services Need

Authors

Introduction Method Discussion References
Back to Table of Contents

Introduction

The aims of this summary are as follows:

- to describe an innovative methodology for assessing children's mental health services need; and
- to describe how this methodology can be applied in documenting the extent and determinants of unmet mental health services need of a sample of children receiving services in five major service systems.
- To document extent and determinants of unmet need for mental health services in a sample of children in five major service systems as well as in the community.

A large proportion of children with serious emotional disorder do not receive treatment. There is a dearth of data regarding the mental health services needs of these children (Silver, 1990). This hinders efficient, efficacious, and equitable mental health services provision.

These factors were crucial in providing part of the rationale for the SED Study. A unique feature of this study is the study of children with serious emotional disturbance across five service settings as well as in a community probability sample. Selected aspects of the study methodology that are relevant for the assessment of mental health services need are provided below.

Return to Top

Method

Sample

A stratified random sample of children aged 9 to 17 years and their parent or caregiver was selected. The total sample size was 1,260; of these, 510 were drawn from a community probability sample and 750 from five service systems (juvenile justice, child welfare, special education, substance use, and mental health).

Measures

The Diagnostic Interview Schedule for Children (DISC 2.3) Service Use and Risk Factors (SURF), was used to document aspects of the following domains:

- demographics
- functional impairment

- medical history
- scholastic information
- family environment
- family management practices
- family history of psychiatric disorder
- pubertal status
- verbal ability
- instrumental competence
- social competence
- self-perceived competence
- parental discord
- service utilization and barriers (including attitudes to mental health use)

Before there can be progress in documenting the extent and determinants of mental health services need of this population, it is necessary to have a methodology for describing mental health services need.

The "Traditional" Approach

The "traditional" approach in attempting to operationalize or quantify the need for psychiatric services in a service area starts with estimating the prevalence of specific disorders and associated impairment from epidemiological studies based on samples of children drawn from the general population. These prevalence rates are then extrapolated to produce estimates of the number of children in a service area that would be expected to meet diagnostic criteria for specific disorders.
Disadvantages of The "Traditional" Approach Using this approach, it is not possible to relate the clinical and contextual characteristics of the child and family to the frequency, intensity, and types of services needed. It is thus not possible to

- assess the extent to which psychiatric need is met through non-psychiatric systems (this is particularly relevant for the SED study since any mental health services received by the subjects are received in five different service systems);
- apply the findings to various geographical areas since services may not be organized in a uniform manner;
- design new types of service delivery in an efficient manner (Brewin, Wing, Mangen , Brugha, & MacCarthy, 1987);
- link the assessment procedure with a framework for knowing what action should be taken when a particular problem is present (Brewin et al., 1987); and
- systematically assess the degree to which individual and aggregate service needs are met.

The Proposed Solution

The proposed solution to the above problems in terms of assessing psychiatric need builds on the work of the Medical Research Council (UK; Brewin et al., 1987) and the New York State Office of Mental Health (Grosser, 1991). The central feature of this solution is to describe mental health services in terms of the types of intervention needed (Bebbington, 1990).

Types of intervention refers to service elements that are generalizable and comprehensible across different organizational units and systems of care. Examples of possible types of intervention are as provided in Table 1.

Application to the SED Study
A list of types of intervention and their definitions will be compiled.

A list will be derived from the clinical experience of the authors, discussions with colleagues, and literature reviews. To estimate inter-rater reliability, 30 subjects in each system will each be rated in terms of their need for each type of intervention by two service providers. Each of these service provides will rate these 30 subjects one month later to establish test-retest reliability. The reliabilities will be reported as Kappa coefficients.

Assessments of psychiatric need will be made for each child by psychiatric clinicians using data obtained from the SED study.

The clinicians will make their assessments on the basis of their clinical experience, published studies regarding the efficacy of particular treatment modalities, and practice parameters developed by the American Academy of Child and Adolescent Psychiatry (Coppans, Jaffe, & Grimes, 1994).

Prior to the assessment of the whole sample, the inter-rater reliability and test-retest reliability of the clinicians' use of the instrument will be established and reported as Kappa coefficients. This will be done by having two clinicians make judgments on 100 subjects and having one clinician make repeat judgments approximately one month apart on 30 subjects.

The types of intervention received by each child will be reported by the service providers (using the instrument described above).

The extent of unmet need will be calculated.

This will be done by ascertaining which of the needs as assessed by the psychiatric clinicians are not being provided by the relevant service system.

The determinants of unmet need level will be ascertained using logistic regression.

The dependent variable will be whether a specific service was provided and the independent variables would comprise the individual, family, and service system characteristics.
Return to Top

Conclusions

In this summary, we described a novel approach to the challenge of describing unmet mental health services need in children and we indicated how this approach would be applied in the analysis if an ongoing project. The data produced will be of greater use to mental health service planners than that available from existing methodologies.
Return to Top

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Return to Top

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Return to Top

Table 1

Return to Article

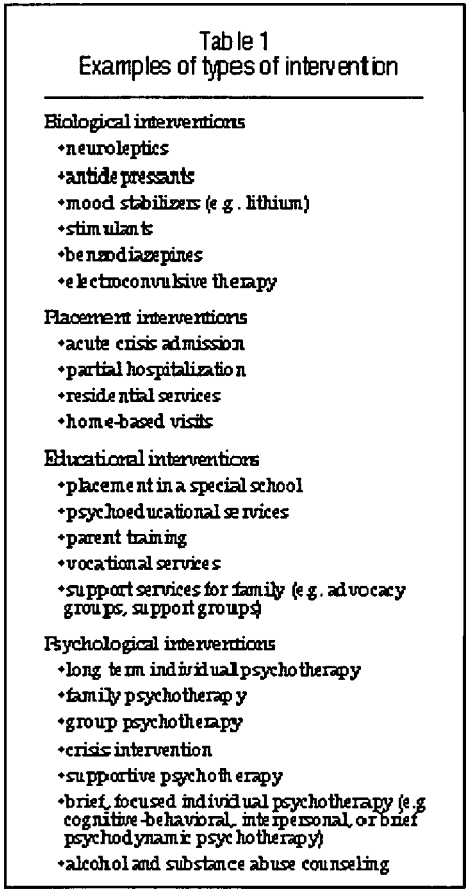

Table 1
Examples of types of intervention

Biological interventions
- neuroleptics
- antidepressants
- mood stabilizers (e.g. lithium)
- stimulants
- benzodiazepines
- electroconvulsive therapy

Placement interventions
- acute crisis admission
- partial hospitalization
- residential services
- home-based visits

Educational interventions
- placement in a special school
- psychoeducational services
- parent training
- vocational services
- support services for family (e.g. advocacy groups, support groups)

Psychological interventions
- long term individual psychotherapy
- family psychotherapy
- group psychotherapy
- crisis intervention
- supportive psychotherapy
- brief, focused individual psychotherapy (e.g cognitive-behavioral, interpersonal, or brief psychodynamic psychotherapy)
- alcohol and substance abuse counseling

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies,
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Developing An Effective, Standardized Client Information System For Child Mental Health Treatment Centers

Authors
Introduction Method Discussion References
Back to Table of Contents

Introduction

Treatment centers face new challenges in providing services for children with severe emotional disturbances (SED). Given limited dollars for human services and the advent of managed care initiatives, they must carefully track the services each child receives, and be accountable for the quality and effectiveness of treatment. Too often there are gaps in essential information about children, interventions and outcomes. Moreover, children with SED access a variety of providers, both public and private. Each center has its own system for documenting care goals and services, but systematic communication between centers, and even within centers, is often inadequate.

Although technology is available to help with client information needs, implementation and use of client information systems within human service organizations has not proven easy (see Bronson, Pelz & Trzcinski, 1988; Cross, Gardner & Friedman, 1993; Hallfors, Cross & Roan, 1993).

Hastily designed systems or "canned" software packages do not necessarily provide the information agencies require and are often not readily adaptable to their particular information needs. Data gathering requirements imposed from higher administrative levels can alienate busy staff, especially if the information appears irrelevant to practice or redundant. Client Information Systems (CISs) are often implemented without adequate staff instruction in maintaining and using data. Lack of standardization impedes the flow of information and makes it impossible to track children across agencies for more powerful analyses of outcomes.

This summary describes the first phases of development of a simple, flexible computerized Client Information Systems (CIS) for agencies who provide services to children with SED. The CIS will enable individual agencies to initiate a carefully developed core data system that they could further refine to meet their individual specification. It will also allow public agencies to collect standardized data about children across multiple systems and limit redundancy by involving the many users of data in choosing key elements. Providers can access information across organizational and professional boundaries to improve treatment. We envision a consortium of centers across the Northeast participating in large evaluation studies of treatment outcome and cost-effectiveness to improve service delivery.

Our primary objective has been to create a Common Data Set structure suitable for use by any center providing day treatment or residential services to children. The database structure will consist of a set of tables, a data dictionary describing relationships among the tables, and written documentation on operation. We are developing this core structure in a one year project, along with a plan for field testing and refinement in the following year.

Developing a CIS that can be used by many different organizations requires overcoming a number of obstacles. Hardware and software incompatibilities are often present, and some agencies have a strong commitment to a particular operating system (e.g. DOS, Macintosh, Windows). Developing software for one operating system is time consuming, and making that software available on a number of systems significantly increases the complexity of the process. Second, agencies differ considerably in how data flows from one part of the organization to another, and what types of data are important for a client database. Considerable discussion needs to take place to discover what data users need and to establish consensus about what core data should be standard. The Brandeis' staff's experiences with a national demonstration project highlight some of the problems involved in implementing a common CIS software package among several organizations (see Cross, Gardner & Friedman, 1993; Hallfors, Cross, & Roan, 1993).

We are suggesting a minimalist approach to the problem outlined above. Our job is to ease the transition from a paper-based system to an electronic CIS for participating organizations.

By providing a comprehensive, core Common Data Set (CDS) structure, we will save time and money for those agencies attempting to develop their own systems, and improve their chances of success. A standardized CIS will allow easy access to evaluation data across agencies, yet each organization will have maximum flexibility in using the hardware and software of its own choice.

In addition, researchers and the consultant are working with key personnel in the public sector, who have responsibility for servicing children with SED. Leaders from Massachusetts government departments such as public education, child welfare, children's mental health, and Medicaid have been invited to share their information needs and perceived trends in reporting requirements.

Return to Top

Initial Steps

Data from Phase I of the project were drawn from five eastern Massachusetts residential treatment centers who serve latency age and adolescent children. All of the agencies utilize some form of computerized client record system representing a variety of hardware and software platforms. The information systems are home grown and have been through several iterations. Most were created in the late 1980's. The organizations are medium sized with annual budgets ranging from 4.5 to 12 million dollars.

Phase I of the project focused on determining which of the hundreds of data elements used by residential treatment centers (RTCs) participating in the project should be candidates for inclusion in the common data set. We began by collecting and analyzing all the relevant computerized data elements that were tracked by the different programs.

It proved somewhat more difficult than expected to gather the data elements from each of these busy agencies. Each differed in their understanding of the project and in their ability to produce the requested information. With perseverance, a reasonably comprehensive picture of the elements being tracked at the various agencies was developed.

To this picture, data elements from the Adoption and Foster Care Analysis and Reporting Systems (AFCARS) published in Federal Register (Vol. 58 No. 244) were added. AFCARS identifies data elements that states will be required to report to the federal government in an initiative to produce national information on foster care and adoption. These elements were added to determine the extent which the final common data set would be AFCARS compliant. However, the addition was not as useful as originally hoped, given that the AFCARS elements represent primarily derived data or the results of initial data analysis. In addition, a core dataset identified by the American Association for Partial Hospitalization (AAPH) Outcomes Measurement Protocol has been entered into the application. The core data set represents a collection of instruments including outcome measures. At the time of this report, these data elements have not been analyzed.

The elements provided by treatment centers were entered into a comparison application. Elements were given a common element name which captured its intended function (see Table 1). Elements were later reviewed and grouped into three categories: core data set, administrative, and other.
To be included in the core data set, elements needed to address the following key questions: What kind of children are served? What kind of services do they receive? When do they enter and leave the

program? Who pays for their care? How do they do after they leave?

As shown in Table 1, only a few elements currently collected can answer these questions. Most of the elements respond to administrative or management requirements. We plan to share these elements with RTCs for their consideration, but would not recommend them for a core data set. For the CDS, we pulled what we could from the list in Table 1, and then considered additional variables that could answer our questions.

Table 2 displays all of the elements being considered for the CDS. Two items deserve special attention. For example, we are developing a unique identifier that, while protecting children's confidentiality in analysis and reporting, will allow them to be tracked throughout their stay, as well tracking returns to this RTC or any other. Ideally, we will develop the ability to track children throughout the health and welfare service system. The identifier may include markers that would allow family members to be recognized in some way. Services to siblings or other family members then could be analyzed without divulging confidentiality. Social security numbers are currently used to validate the right record for the right child. Social security numbers mask a child's identity to some degree, but require additional security to protect confidentiality.

We are also paying special attention to the outcomes variables. The ones listed in this paper have caused us to ask additional questions. For example, how will the outcome variables be used? Will RTCs be compared for their outcomes? Will attention to outcomes make RTCs avoid the most problematic children? Measuring outcomes has become quite fashionable, but each outcome indicator must be considered carefully for the conclusions it implies.

Return to Top

The Next Steps

During the next phase of the project, we will develop an advisory committee to review all data elements and make recommendations for further changes in the core data elements. The advisory committee will consist of representatives from the RTCs, state agencies, consumers and researchers. All elements will be subject to discussion and debate over inclusion in the CDS. Those variables that finally are included will then be defined and operationalized for programming in a relational data base. The data base will be piloted in six RTCs and further refined by the advisory committee as needed. We envision this to take place over a two-year period, at which point we will make the data set available for a much wider circle of RTCs.

Return to Top

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Return to Top

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Return to Top

Table 1

Return to Article

Table 1

Common Data Set Elements

Data Element	RTC 01	RTC 02	RTC 03	RTC 04	RTC 05	ABCARS	Data Element	RTC 01	RTC 02	RTC 03	RTC 04	RTC 05	ABCARS
Client Number	X		X	X	X		Contact Last Name	X	X	X	X		
Client Last Name	X	X	X	X	X		Contact First Name	X	X	X	X		
Client First Name	X	X	X	X	X		Contact MI	X	X	X	X		
Client MI	X	X	X	X	X		Organization Name	X	X	X	X		
Alternate Name		X	X				Contact Street	X	X	X	X		
Client ID Number	X	X	X				Contact City	X	X	X	X		
Client Street Address		X	X	X	X		Contact State	X	X	X	X		
Client City		X	X	X			Contact Zip Code	X	X	X	X		
Client State		X	X	X	X		Contact Work Phone	X	X	X	X		
Client Zip Code		X	X	X	X		Local Education Authority	X	X	X			
Client Phone Number		X	X	X			School Last Attended	X	X				
Date Interviewed	X	X					Entry Grade Level	X	X	X			
Date of Birth	X	X	X	X	X	X	Current Grade Level		X	X			
Date of Admission	X	X	X	X			SPED Prototype	X	X	X			
Date of Discharge	X	X	X	X			Date Most Recent Case		X	X			
Client Program	X	X	X	X	X		Next IEP Review	X	X	X			
Program Site	X	X	X	X	X		Diagnosis		X	X	X		
Case Manager	X	X	X				Client Physician	X	X				
Birth Place	X	X					Health Carrier	X	X				
Citizenship	X	X					Health Plan Number	X	X	X	X		
Client Current Address	X	X	X				Physician Work Phone		X				
Primary Language	X	X	X				Physician Home Phone	X	X				
Previous Placement	X	X					Medications	X	X				
Height	X	X					Medication Dosage	X		X			
Weight	X	X					Allergies	X	X	X			
Hair Color	X	X					Immunization Date	X	X				
Eye Color	X	X					Immunization Type	X	X				
Grades		X	X	X	X		Self Preservation Ability	X	X				
Race	X	X	X	X	X		Medical History	X	X				
Number of Siblings	X	X	X				Funding Source Code	X	X	X			
Referral Source	X	X	X	X			Rate Amount	X	X				
Referral Region	X	X					Percent of Cost	X	X	X	X		
Identifying Marks	X	X					Billing Frequency	X	X				
Services Requested		X	X				Funding Agency	X	X	X	X	X	
Client Status		X	X				Funding Contact Name	X	X	X			
Relationship Code	X	X	X				Funding Contact Street	X	X	X			
Legal Guardian	X	X					Funding Contact City	X	X	X			
Family Last Name	X	X	X				Funding Contact State	X	X	X			
Family First Name	X	X	X				Funding Contact Zip	X	X	X			
Family Street	X	X	X				Funding Contact Phone	X	X	X			
Family City	X	X	X				Funding Contact Fax	X	X				
Family State	X	X	X				Funding Start Date	X	X	X			
Family Zip Code	X	X	X				Funding End Date	X	X	X			
Family Home Phone	X	X	X				Funding Notes	X	X				
Family Work Phone	X	X	X				Incident Date	X	X				
Restrictions on Visiting	X	X					Incident Time	X	X				
Family Date of Birth		X	X				Incident Location	X	X				
Contact Type	X		X	X			Incident Type	X	X				

[Home] [Search] [Index]

Table 2

Return to Article

Table 2

Elements for Common Data Set

Domain	Element
Client demographic information	Client number
	Client social security number
	Client zip code
	Date of birth
	Gender
	Race
Program information	Date of admission
	Referral source
	Presenting problems
	Date of discharge
	Reason for discharge
	Placement at discharge
	Living environment restrictiveness code at discharge
Living situation and history	Living environment at intake (code)
	Living environment restrictiveness code at intake
	Location of environment (zip code)
Family information	Family zip code
	Relationship code
Education information	Current Grade Level
	SPED prototype
	Date most recent core
Medical Information	Diagnosis
	Health carrier
	Medications
	Date Medication Prescribed
	Who Prescribed (code)
Funding information	Funding source code
	Rate amount
	Percent of cost
Service history	Treatment programs immediately prior to admission
	Services requested
	Services delivered during treatment
	Services being delivered by another agency
	Services recommended at discharge
Behavioral events	Incident date
	Incident type
Outcomes	Living environment (restrictiveness, stability)
	Attendance at school or work
	Academic progress
	Life satisfaction
	Substance abuse
	Substantiated reports of child abuse & neglect
	Arrests
	Violent behaviors (including sex offenses)
	Sexually transmitted diseases
	Pregnancy/parenthood out of wedlock

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Enhancing the Methodology of Social Validation: A Survey of Child and Family Service Issues

Authors

Introduction Method Results References
Back to Table of Contents

Introduction/Purpose

Social validity relates to the idea that behavioral interventions and outcomes must be validated by individuals and communities being served. Social validation research, and the related, but more public policy oriented, Community Concerns Report Method represent a simple, direct methodology for asking customers what their needs are and how satisfied they are with current services (Schriner & Fawcett, 1988). This approach evolves from a body of behavioral research on social validation that first made the case for subjective measurement of behavioral interventions (Kazdin, 1977; Wolf, 1978).

As the scope of social validation research broadens to include public policy issues, questions remain regarding reliability and validity (Fawcett, 1991; Storey, 1992; Storey & Horner, 1991). The Southern Consortium for Children (SCC) Survey of Child and Family Service Issues builds upon the work of the Pennsylvania Project Social Validation Survey (VanDenBerg, Beck, & Howarth, 1992), by adapting a previously used survey instrument for field testing in Appalachian Ohio.
The purpose of the study was to apply appropriate psychometric tests to data already collected by the Pennsylvania Survey, to alter items where indicated, and to pilot the resulting instrument in four Ohio counties in an attempt to evaluate reliability and validity. The resulting instrument is available for use elsewhere, encouraging more uniform methodology in further social validation research. The study was carried out in two distinct phases.

Return to Top

Methodology and Findings, Phase One

Overview of Pennsylvania Project Data
The Pennsylvania Survey was designed to obtain some measure of the opinions of stakeholders in Pennsylvania's children's services system. Specifically, this survey asked stakeholders to rank the level of importance of selected children's issues and their satisfaction with how these issues were addressed. The goal was to identify issues of both high importance and low satisfaction, and to target those issues for the development of program outcome measures.
Seven hundred Pennsylvania stakeholders were asked a series of questions regarding the importance and satisfaction levels associated with various children's issues. Children's issues were categorized into the following life domain areas: educational, vocational, safety, living arrangements, family life, emotional and psychological, medical and psychiatric, social and recreational, cultural, spiritual, and legal issues. Respondents chose
from among values on a Likert type scale for both importance and satisfaction levels on 49 questions, effectively yielding 98 separate survey items. For all questions, the choices were 1, 2, 3, 4, and 5, with 1 being the least important or least satisfied and 5 being the most important or most satisfied.

Ten specific groups of individuals were identified as stakeholders of children's services. The ten identified groups were: children age 12 or older, parents of children younger than 12, parents of children age 12 or older, community agency workers, board members of agencies, school board members, juvenile court judges, local legislators, informal community leaders, and poverty-level representatives.

Phase One Procedures
In phase one of the study, data collected in the Pennsylvania Survey were secured so that an item analysis could be performed in an attempt to obtain a meaningful measure of instrument reliability. Specifically, internal consistency was measured using Cronbach's (1951) coefficient alpha, which is a commonly accepted formula for assessing the reliability of a measurement scale with multi-point items. Survey items were split into life domain areas and further along the dimensions of importance and satisfaction, yielding 22 separate sets of data. Within each data set, a coefficient alpha value was determined for each set when one item was deleted, one item at a time. This allowed for the identification of items that significantly eroded internal consistency.

Further statistical analysis was carried out to assess the significance of reported variability between child clients and all other respondents, and between groups closest to services and those groups one step removed from services. An independent groups t-test (Jaccard & Becker, 1990) was performed comparing the mean ratings for each of the comparison groups described above.

Phase One Findings
Given the fact that the survey instrument is in an early stage of development and there were a small number of items in each life domain data set, alpha values of .6 across the dimension of importance and .7 across the dimension of satisfaction were considered to be adequate indicators of instrument reliability. This was found to be the case in 15 of the 22 data sets, which was considered to be evidence in support of reliability. The instrument was found to be reasonably reliable, in general. Life domain areas that did not meet the standard across both the dimensions of satisfaction and importance were selected for alteration, while those that exceeded the standard were considered to be reliable and were included in the instrument for field testing in Ohio without changes. The Pennsylvania Project staff also suggested two minor changes based on previous experience. In all, at least one item within 8 of the 11 life domain areas was selected for alteration in phase two of the study.

It was intuitively felt that an instrument of reasonable reliability would be able to discriminate between child and non-child respondent groups, and between those closest to services and respondent groups one step removed from services. A positive finding in either or both instances was to be considered evidence in support of construct validity.
When independent groups t-tests were performed on both comparison groups, results were significant. Statistically significant differences were discovered in 29 of 44 data sets, overall. The direction of significant differentiation was very consistent between respondent groups across life domain areas. Evidence in support of construct validity was found to be present in phase one of the study.
Return to Top

Methodology and Findings, Phase Two

Phase Two Procedures
Stakeholders of child and family services were selected for participation in phase two of the study in Athens, Jackson, Washington and Lawrence Counties in rural, southeastern Ohio (N = 192). Stakeholder groups were the same as the Pennsylvania Project Survey with the exception of the poverty level representatives, who were excluded at the suggestion of Pennsylvania Project research staff.

It was decided that when at least 60 valid responses were received, the statistical analyses described in phase one would be repeated and a follow-up interview would be conducted with 10 individuals. Interview candidates were nominated by mental health agency workers and represented all stakeholder groups, with the exception of judges. Independent groups t-tests were performed only where significant differences between groups were discovered in phase one of the study.

Phase Two Findings

The minimum standards for values for Cronbach's alpha established in phase one of the study were exceeded in all but 2 of 22 life domain data sets in phase two. Values for alpha were increased in 8 of 11 instances across the dimension of satisfaction, and in all instances across the dimension of importance.

Independent groups t-tests were performed using pooled variance estimates on nine data sets where child-client ranking of satisfaction levels significantly differed from other groups in phase one. There were significant differences in four of nine data sets.

Independent groups t-tests were also performed on the eight data sets where significant differences were discovered in phase one between child clients and all others in their ranking of importance. There were significant differences in two of eight data sets.

Similarly, independent groups t-tests were performed on respondent groups closest to services, and groups one step removed from services in ranking of importance and satisfaction where significant differences were present in phase one data. There were no significant differences found in any of the seven areas when ranked for satisfaction. When ranked for importance, a difference was found in only one of five areas examined.

When semi-structured follow-up interviews were conducted among 10 survey respondents, a high degree of satisfaction was reported with the content, clarity and significance of the questionnaire. When specifically asked about the importance of the life domain areas chosen for study, they were universally endorsed. The follow-up interviews yielded no significant negative comments.

Return to Top

Summary & Conclusions

An increase in values for Cronbach's alpha in 20 of 22 life domain data sets represents compelling evidence in support of enhanced instrument reliability for the altered questionnaire that was field tested in Ohio. However, the performance of independent groups t-tests in phase two, failed to convincingly replicate the phase one study. Little new evidence in support of construct validity was yielded in phase two. The follow-up interview suggests a high degree of overall respondent satisfaction with the instrument, and the one specific question regarding the importance of included life domain areas provides an indicator of content validity.

It is expected that enhanced methodology in social validation research will increase its viability and help to more clearly place this approach in the larger context of health and human service policy development. Specifically, it is anticipated that the application of psychometric measures to survey data will help to increase consumer participation in the design of child and family programs in Ohio and beyond.

The SCC is dedicated to an outcome manage-ment approach that includes consumer choice and contributes to the overall responsiveness of services. Working closely with families, service providers and community groups, the Survey is being used as part of a backdrop for the development of relevant outcome measures across systems and life domain areas.

Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

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Making "Cents" of Outcome Measures in a Partial Hospitalization Setting

Authors

Introduction Method Results Discussion References
Back to Table of Contents

Introduction and Purpose

The purpose of this project was to design effective and efficient outcome measures for a youth partial hospitalization (YPH) program. The design was required to utilize information obtained through the existing intake structure, as well as to provide immediate information that could assist in treatment decisions, treatment planning and the design of interventions. The resulting design must also obtain information across several sources and serve as a means for monitoring clients' progress. Additionally, the instrument to be selected required appropriate standardization and must be acceptable for use in the YPH setting. Finally, it needed to be cost effective and easily incorporated into the established role of the therapist. Once the design was developed, a pilot was initiated. This summary presents the design of the outcome measurement process and results of the first six months of data collection.

Return to Top

Method and Procedures

The design described in this summary was developed and implemented in a partial hospitalization program setting which serves youth who experience significant emotional and behavioral difficulties. The YPH setting is part of a larger community mental health system of care in Dayton, OH. Individuals who are referred to this program demonstrate severe symptoms of emotional or behavioral disorders which interfere with successful functioning within the structure of the school, home and/or the community, however they do not require hospitalization. Treatment goals include preparing the youth for return to community settings with behaviors that are manageable and appropriate to the situation. Therapy includes work in groups, in individual sessions, and family sessions. Academic instruction is provided daily through a tutoring model.

The Achenbach Child Behavior Checklist (CBCL) was selected to obtain behavioral data due to its multimodal and multi-informant format. The instrument met design criteria, because it can be administered to parents, teachers and youth, yields a cross-informant profile for response comparison, and has been standardized (Achenbach, 1991). The results provide a profile that delineates internalized behavior (e.g., with-drawn, somatic complaints and anxietydepression) from externalized behavior (e.g., delinquency and aggression). Social problems, thought problems and attention problems can also be identified. The scales are easy to complete, and results can be compiled quickly with the aid of computer scoring. It was felt that it would be feasible to incorporate information provided by the CBCL into treatment planning and intervention design.

Client information from the initial intake
and existing client records contributed to the comprehensiveness of the outcome measures. The following variables were considered: gender, ethnicity, age at admission, initial primary diagnosis, initial secondary diagnosis, most frequent medications used, length of stay, global assessment of functioning (GAF), and use of additional services.

Clinically, it was expected that three specific areas would be included in the development of acceptable outcome measures: level of functioning, severity of symptoms, and client satisfaction. Table 1 describes the resulting evaluation design.

Two data collection points were established. The first occurred at admission and the second during a six month review. The data were analyzed using a paired samples T-test to determine whether significant change occurred during the first six month of treatment. Results from the CBCL were compared to determine specific areas of significant change.

Return to Top

Results

The results of the paired samples T-Test for the initial and six month data provided insight into the effectiveness of the YPH intervention. The parent or primary caretaker reported a significant reduction in the youths' anxious/depressed behavior, aggressive behavior and externalizing behavior (see Table 2). The teachers working with the child in the treatment milieu reported a decrease in externalizing (acting out) behavior. The most significant finding related to the youth's perception of their own behavior. Youth reported that after six months they experienced less withdrawal, a decrease in social problems and a decrease in attending problems. The youth self report total scale indicated significant changes across these measures.

The initial placement profile that resulted from the collection of demographic data is shown in Table 3. The initial profile of the client was considered in concert with the CBCL measures. The CBCL's Internalizing and Externalizing scales helped to identify specific behaviors related to the diagnosis, allowing the treatment plan and intervention selection to be directly related to the symptomatology. Initially, it was anticipated that Attention Deficit Hyperactive Disorder (ADHD) would be the most common primary diagnosis. The results of the pilot study, however, identified Dysthymia as the most frequent primary diagnosis, and Oppositional Defiant Disorder as the most frequent secondary diagnosis. It appeared that therapeutic intervention for depression might be as important as redirecting the externalizing behavior. Considering the most frequent primary and secondary diagnoses, the most frequent medications used were as expected&shyp;Prozac (anti-depressant) and Ritalin, often prescribed to address externalizing behavior. These results suggested that a combination of interventions was necessary to promote positive outcomes, including psychotherapy, behavior change and medsomatic services. Results also supported the utility of a transdisciplinary approach to service provision.

The 180 day length of stay (LOS) was identified as the baseline measure for program planning. To impact LOS, increased services to support the successful transition of clients to the least restrictive appropriate environment must be developed. Case management and foster care services are utilized in conjunction with YPH program within the system of care model, and can help support these transitions. Collaboration with the schools will also be a critical link to accomplish this goal.
Additionally, the results indicated that the lower the score on the GAF upon intake, the longer the length of stay. This information will help predict the level of financial support required from funding sources for individual clients. In future studies, it is anticipated that examination of these factors will yield an anticipated LOS upon intake.

Return to Top

Discussion

It is likely that comprehensive services for youth who have severe emotionally disturbances support the ultimate goal of preventing future inpatient hospitalization and residential care.
The YPH program will use results of the outcome measures to focus their efforts in making the continuum of care accessible to children and adolescents in need of mental health services. Program standards will be reviewed to ensure that age appropriate and/or developmentally appropriate types of

services are made available. Skill groups, for example, could meet the needs of a specific age group (e.g., sex education, anger management, or independent living skills).

The initial results of this study have had a great impact on refining the direction of the YPH program. The information from this study will be used in both treatment planning and program development, and should garner agency support of the outcome measure process. Ultimately, information obtained from outcome measures will be critical in the justification of managed care dollars and authorization of services for children, adolescents and their families.

Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

Table 1

Return to Article

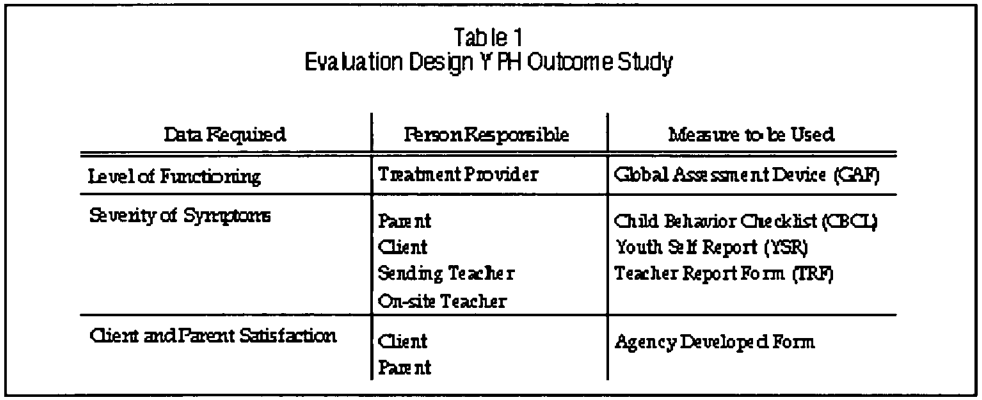

Table 1
Evaluation Design Y PH Outcome Study

Data Required	Person Responsible	Measure to be Used
Level of Functioning	Treatment Provider	Global Assessment Device (GAF)
Severity of Symptoms	Parent Client Sending Teacher On-site Teacher	Child Behavior Checklist (CBCL) Youth Self Report (YSR) Teacher Report Form (TRF)
Client and Parent Satisfaction	Client Parent	Agency Developed Form

417

420

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

A Functional Integrator in Systems of Care Research on an Operational Language for Service Planning

Authors

Introduction Method Results References
Back to Table of Contents

Introduction/ Purpose

As systems for care for youth with serious emotional disturbances are designed and implemented, deficiencies of the existing methods of service planning have been identified. Some methods use language that is unfriendly to families&shyp;medically oriented categorical diagnoses, for example, create barriers for families, and may not guide appropriate professional intervention. Some are operationally explicit, but do not accommodate or embrace a wide range of clinical approaches.

Some methods of service planning do not take into account the purposes of different systems (e.g., child welfare vs. special education). Because of these shortcomings, systems of care, despite efforts to achieve structural integration, often find it is difficult to achieve functional integration&shyp;that is, operational approaches to service planning that can be used throughout and across a system of care.

This summary presents evaluations of a method of service planning that responds to these problems. This method was designed to be operationally explicit, family-friendly, conducive to the integration of clinical experience and multi-agency competency into service planning, and use of a language of service planning that will "work" across systems.

Focal, factor-based service planning (FFSP) was developed in a hospital setting and has been used in a community-based agency (Harper, 1989; Harper & Cotton, 1991). FFSP assumes that service planning can be explicit and operational, comprehensive and coherent. It's design is based on the assumption that it is possible and preferable for parents and youth to participate in the development of the service plan. In addition to family participation in planning, FFSP values the use of least restrictive alternatives, and parsimony&shyp;the definition of modest goals at each stage&shyp;doing what needs to be done, not all that could be done.

FFSP begins with selection, from among many potential problems, of a single Focal Problem, which is explicit, actual, and defined in terms that all parties can agree on. A corresponding Goal is then defined. Contributing Factors, those elements in the life of child, family, community or systems of care felt to contribute to the Focal Problem, are identified, and Intervenable Factors chosen. Corresponding Interventions, Objectives and Target Dates can then be defined. The Focal Problem and Goal and the Selected Factors must be stated in language that can be shared with the youth and with parents. The overall plan is guided by an explicit Discharge Picture. Criteria for Focal Problem, Goal, and Factors are given in Table 1; questions to use to check on the plan are given in Table 2.

The Focal Service Plan does not include everything known about the child; it complements and does not take the place of clinical diagnoses; and is not a complete problem list.
This summary presents results of the evaluation of FFSP in hospital and community settings and suggestions for implementing its use in systems of care.
Return to Top

Method/ Procedures

For this evaluation research, two sites were chosen. One, an inpatient psychiatric service in a teaching children's hospital, had used FFSP (there, called Focal Inpatient Treatment Planning, FITP) for several years (Harper, 1989; Harper & Cotton, 1991). The other, a community-based family service agency, had begun using FFSP in the previous year. The staff and trainees in these two sites represented a wide range of experience and came from multiple disciplines.

The evaluation questions were, (1) What perceived advantages does FFSP have for clinicians? (2) What is the impact on clients? Is FFSP relevant to long-term outcome? (3) How do experienced and trainee clinicians learn to use FFSP? and (4) How is the method used in multidisciplinary meetings? Data were gathered through observations of team meetings and semi-structured interviews with clinicians by one of the authors (J. Barnes).

Return to Top

Results and Implications

Observations in team meetings and comments in interviews indicated that FFSP was indeed being used, both in home-based and inpatient services. It was experienced as useful in both settings, for example, in identifying the unique aspects of each case, and decreasing the risk of "losing the forest for the trees" in complicated cases. Respondents reported that they appreciated having a language that could be shared among family members and providers from different disciplines.

FFSP was reported to have empowered clients by stating the work to be done in terms that youths and parents could understand and by emphasizing strengths and reachable goals. It stated mental health problems in non-pejorative language that could be shared with other family members. It was felt to facilitate work between clients and clinicians, and to clarify targets for other professionals.

Moving beyond these preliminary, subjective assessments, issues for further research included determining optimum training strategies; finding the best methods for generalizing use of FFSP between settings; assessing clinician satisfaction and advantages for clients in a more systematic way; and evaluating the contribution of FFSP to longer-term implementation of goals. Semi-structured interviews with clinicians differing in experience, discipline, and setting, interviews with children and parents, and observations in teams will help to address these issues.

In the meantime, the use of FFSP will respond to external incentives. There is community pressure for participation in planning, while accrediting and reimbursing agencies increasingly require evidence of multi-disciplinary treatment planning with explicit goals and objectives. The use of the FFSP methodology should also increase in response to internal incentives&shyp;such as care providers' frustration at getting "bogged down" in data-rich cases where a goal is difficult to define, and their desire to pool input from professionals and community members alike.

As to implementation, our observations suggest several necessary conditions. On the institutional level, these include a mandate for explicit, participatory service planning; and the provision of needed resources, in terms of time, training, hardware, and the development of forms suited to this kind of service planning. Among personnel, implementing FFSP requires openness to learning new ways to organize clinical data, perhaps divergent from traditional practice; the capacity at each phase of the work to step back and reflect on the planning process itself; and a commitment to consensus development and participatory service planning.

Implementation requires that staff development be thought of as a process, not as a one-time training session; that it emphasize learner-directed, experiential learning; and de-emphasizes paperwork, or "getting the right form" as the solution to the challenges of service planning. Training must address critical knowledge, skills, and attitudes. Staff must learn that categorical diagnoses do not determine the content of treatment; they must learn how to use criteria for defining the problem being treated, the contributing, and the intervenable factors; and they must learn that obfuscation in service planning is not only a problem in documentation, but in clinical practice as well. They must become skilled in monitoring the planning process, listening at each phase for the degree of consensus, and in defining factors, especially intervenable factors, out of clinical data. They must adopt the values of critical listening, parsimony in planning, and participatory planning.

Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

Table 1

Return to Article

Table 1
Focal, Factor-based Service Planning

Criteria for the focal problem

1) States symptoms of condition of the child.
2) States the real reason for treatment, including relevant aspects of context, in terms all can agree with, and in language that facilitates alliance formation and parsimonious definition of the goal.

Criteria for the goal

1) Is the "flip side" of the Focal Problem.
2) States those changes that will remove or decrease the problem requiring services, parsimoniously defined.

Criterion for contributing factors

1) Those features of the child's life that contribute to or perpetuate the Focal Problem.

Criteria for selecting factors

1) Can be changed during services.
2) Change in the Factor will produce change in the Focal Problem.

Criteria for strengths

1) Are those features of the child's life that mitigate the Focal Problem or provide a point of leverage in working on it.

Table 2

Return to Article

Table 2
Focal, Factor-based Service Planning

Questions to check on Focal Problem

1) Is this what *really* got the child to services? Where are most children with this problem?
2) Can all parties agree on this definition of the Focal Problem?
3) Has the Focal Problem been stated in jargon-free language, useful for building an alliance?

Questions to check on the Goal

1) Is this Goal the "flip side" of the Focal Problem?
2) Is this a parsimonious statement of what has to change for the child not to require services?

Questions to check on Factors & Strengths

1) Do the Factors capture our best understanding of the child?
2) Are some of the Factors near enough to the child's experience that he/she would recognize them and respond emotionally?
3) Have we identified relevant Strengths?

Questions to check on selection of Factors

1) Does this "short list" capture what needs to change for the child to be able to leave services?
2) Do we really believe that change in these Factors will allow the child to leave services?
3) Are there other changes we expect to occur with services that we have not yet defined?
4) Do the defined interventions correspond to the selected Factors?

Questions to check on Overall Plan

1) At which levels of the plan does consensus exist? Where is there lack of consensus?
2) Have we captured the child's point of view? Can we hear the child's voice in the treatment plan?
3) Is the Discharge Picture explicit?
4) Is the whole plan informed by the Discharge Picture?

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

An Alternative Approach to the Study of the Children's Mental Health Service Systems: Anthropological Models

Authors

Introduction Method Discussion References
Back to Table of Contents

Introduction and Definition

This summary explores the use of medical anthropology models to explain the relationships between parents of children labeled seriously emotionally disturbed and service providers. Today the values and practices of community service providers are moving away from institutionalization and toward community care and "individualized service models" (Burns & Friedman, 1990:95). This shift includes the recognition that the family of a child with a serious emotional disturbance requires as much support as does the child. Of equal importance, parents are becoming recognized and valued as the experts in their children's problems and needs, and are beginning to participate in service planning for their children.

In the new individualized service model, "the concept of a partnership between parents and professionals expands the more traditional roles of 'patient' and 'client' the parents tend to assume" (Friesen & Koroloff, 1990). As this service model becomes more accepted by all services and providers in the children's mental health service systems, a better understanding must be gained about what is happening in the relationships between the parents and providers.

Medical anthropology has a number of established theoretical models that address the relationship between patients and healers, which are used here to examine this relationship in the children's mental health service systems. Medical anthropology models are sociocultural models that recognize that the system's context is necessary in studying the strategies a family uses to seek and obtain care and support for a family member with medical or psychological health problems.

Return to top

Method

Medical anthropology models were used to analyze families' strategies for seeking and interacting with the available services, such as the special education schools explored in the case study. Data analyzed were from a qualitative multiple-case study of two families. In depth interviews, conducted in 1992, with young men and mothers explored their interactions with the schools and other service providers. The families were participants in the National Adolescent and Child Treatment Study (NACTS), a research project conducted by the Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Florida Mental Health Institute (FMHI), University of South Florida (USF).

Anthropology of Biomedicine

The Anthropology of Biomedicine model is primarily cognitive. This approach and model "focus on what sickness and health mean to individuals and how, as a consequence of these meanings people act in specific ways regarding treatment" (Lazarus, 1988). Kleinman (1980), had developed an explanation for the anthropology of biomedicine model. He uses the concept of "explanatory models", which are notions held by the patients, families and practitioners about specific episodes of illness (Kleinman, 1988).

Explanatory models may include cognitive, affective, moral and social concerns (e.g., specific health beliefs, fears and concerns about health, stigma of SED label, etc.)
For the child with a serious emotional disturbance, the lack of mutual understanding on the part of his/her family and the school personnel can cause miscommunication resulting in long-term consequences for treatment decisions and outcomes. The Anthropology of Biomedicine model is well suited to explain miscommunications and family noncompliance with the school personnel's treatment recommendations.

EXAMPLE - Case Study A1: Mother, Dana Mae Dodd; Son, Chuck Dodd; and Special Education Teacher, Ms. M.

Dana Mae Dodd and Ms. M. struggled to understand and work with each other. They each had their own perspective and explanatory model.

Dana Mae expected to have a lot of say and influence in how Chuck was treated at the day treatment facility. She kept in close contact with the teachers and expected to hear about problems on a daily basis, if needed. Dana Mae was assertive, she said "... I got what I wanted because I demanded it. I didn't ask, I demanded it when it came to my young-un...over the years the teachers and I have learned to work together."

Ms. M. explained how irritating Dana Mae's behavior could be when she called constantly and sent notes to school that were not written clearly. Ms. M. acknowledged that Dana Mae had her good points, saying, "She seems genuinely concerned. He [Chuck] does get his medicine when things get serious enough. ... She is better than most of the parents. I see some of the same behaviors in Chuck as I do in Dana Mae."

Dana Mae's belief that she should have daily input into Chuck's treatment often clashed with Ms. M.'s beliefs on how best to teach Chuck. This led to tension between the two women and problems in providing Chuck the best care.

Critical Medical Anthropology
The Critical Medical Anthropology model incorporates "political and economic determinants of society into studies of health and medicine" (Lazarus, 1988:45). The personal experience is seen as taking place in the social context of the society as a whole . Health is defined in this model "as access to and control over the basic material (e.g., transportation, medication) and non-material resources (e.g., education, health information, therapy) that sustain and promote life at a high level of satisfaction" (Baer, Singer, & Johnsen 1986).

The critical medical anthropology model places the family-service provider interactions in the context of the children mental health service systems. The context influences the available services, beliefs about mental illness in children, and the "asymmetrical social relations based on social class and authority", which all become critical parts of the analysis and model (Lazarus, 1988).

EXAMPLE - Case Study B: Mother, Beth Brennan; and Son, Calvin Brennan
Beth wanted to know what was wrong with Calvin. At one time she had wanted him to have a neurological examination. She said "I wanted the examination of the brain, the head, to see if, where the problem was coming from. If it was something mental, psychological, something I did, something I did when I was pregnant ... or anything. I wanted more help. Medical help or advice which we didn't get."

She explained why they did not get more help: "Money I guess. ... Nobody ever recommended it. It wasn't paid for through the school and we didn't have the money to do it ourselves. His insurance didn't cover stuff like that." The asymmetrical social relationship between the school personnel and Beth meant that Beth felt she did not have the right or knowledge to question the actions of the teachers and administrators. Calvin never did get a neurological exam because of economic, communication, and service system barriers.

Return to top

Summary and Implications

In the children's mental health service system there is growing recognition that there must be a true partnership between the parents and service providers. There is also a conceptual shift towards families of the mentally ill in terms of "a model of stress, coping, and adaptation [that] views familial behaviors as coping strategies," rather than as interfering with prescribed treatments, or as toxic agents (Lefley, 1989).

Medical anthropology models are well suited to examine what happens within the relationships developed between the families of children with mental health problems and the services providers, e.g. special education schools. Of particular interest was using the models to examine the family and school personnel interactions and their ability to cooperate in the care of the child. The models are also useful in exploring the reasons why the family and child did or did not comply with the treatments and instructions provided by the schools.

Return to top

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Return to top

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Return to top

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[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Information Equity: A Critical Component of Strong Service Systems

Authors

Information Method Results Discussion References
Return to Table of Contents

Information and Referral

Information and Referral (I & R) is a system designed to link a person in need of information about human services with needed resources. "I & R represents a continuum of functional elements ranging from information assistance and advice-giving to referral and follow-up" (Levinson, 1987, p. 914). I & R services generally provide information to individuals who telephone an agency, describe a problem, and request assistance. Trained staff assess the nature of the problem(s), provide information, and advice, appropriate referrals to existing resources, and follow-up to determine if services were obtained. "Varying levels of counseling and advocacy are offered in accordance with the user's needs and the mission of the I & R organization" (Levinson, 1987,
p. 914). There are several different types of I & R services but most can be classified as one of the following:

General Assistance: agencies that serve all segments of the population and deal with a wide range of social problems.

Specialized: agencies designed to meet the needs of a specific target population (e.g., individuals with disabilities), to deal with a significant social problem (e.g., HIV/AIDS), or to provide a specific service (e.g., crisis intervention).

Full Service: agencies that serve all segments of the community and address a wide range of social problems; in addition, these agencies conduct and participate in a variety of community planning and needs assessment activities to improve the continuity of care in the human service system.

The philosophy of I & R is that being "information poor" is a handicap in obtaining services; being "information rich" enables one to reap the benefits of a service system (Levinson, 1987, p. 919). One goal of I & R agencies is to provide information equity so that individuals in need of help can obtain services in a timely manner.

Return to Top

Importance of I & R Services

Early intervention is considered to be an important factor in the successful treatment of at-risk children and their families. Unfortunately, it is often difficult for people to identify and locate services in the early stages of a crisis. For example, 57% of respondents in a community needs assessment study reported that they did not get help for a personal or family problem because they "thought no help was available" (ICOPE, 1992). Whereas only 10% of the general citizenry in another study reported that they did not know where to find the help they needed (Balducci, 1994), this rate was 16% for low-income respondents, 23% for individuals who had experienced a serious problem within the last year, and 45%

for Spanish-monolingual respondents (Montenegro & Batsche, 1995). Lack of familiarity with service systems and service providers is a major barrier that reduces opportunities for early intervention.

In a recent article on early intervention with children with serious behavior problems, Dunlap and Fox (1995) describe "family support" as one of the major elements of comprehensive early intervention services. They refer to family support as "any and all actions that serve to strengthen the family system, especially as these actions pertain to the family's assimilation and understanding of their child's disability" (Dunlap & Fox, 1995, p. 18). Among the supports they describe are the need for information, education/training, and social and emotional support. Although the provision of on-going intervention is beyond the scope of I & R services, these organizations do provide information to help with the initial identification of service providers, support groups, and community activities. I & R counselors are also trained to teach families how to operate within a community-based social service system, i.e., self-advocacy training. Finally, I & R counselors serve as a source for help for individuals in need of emotional support for long-term problems and stresses.

In summary, I & R services are often the entry point into the system of care for children and families. These agencies can provide individualized ongoing support and services ranging from self-advocacy training to 24-hour social and emotional support. Little has been published describing the role of I & R agencies as part of early intervention strategies, a family support service, or a critical component of the continuum of care. The objectives of this project were therefore to:

1. identify sources of information used by individuals when they are in need of help;
2. identify barriers to obtaining information about community services that may prevent individuals from seeking early intervention assistance; and to
3. conduct an analysis of "counseling" calls received by an I & R agency to determine the nature of the crisis, the extent of intervention provided by phone counselors, and the extent to which counseling calls were referred to other service providers.

Return to Top

Procedures

The methods used to address objectives one and two were focus groups, key informant interviews, and a survey of citizens. Focus groups and interviews were conducted with consumers of mental health and other social services and representatives from community social service agencies and organizations, state/county social service agencies, information-service agencies, and community churches and synagogues in Pinellas County, Florida. In selecting consumers to participate in the focus groups, target populations were identified who were representative of the demographic and cultural composition of the community including: Southeast Asian consumers, African-American consumers, and the elderly population. The social service providers included representatives from community schools, hospitals, public health centers, child care centers, domestic violence shelters, family service centers, mental health centers, and substance abuse treatment centers. The state/county agencies included representatives from Health and Rehabilitative Services, Juvenile Justice, Public Health, and Social Services. The participants in the focus groups with social services providers and state/county agencies were selected in consultation with members of the Pinellas County Interagency Council on Planning and Evaluation. Agencies were invited to participate who had extensive experience in dealing with individuals seeking assistance from public sector programs and services.

Finally, a survey of the general citizenry was conducted to identify the information-seeking behaviors and preferences of citizens of Pinellas County. One hundred citizens, selected at random at a community shopping center, were asked to identify the information sources they would use if they were in need of help.

The analysis of the counseling calls (objective three) was conducted by reviewing the case records of all counseling calls received by a community I & R agency in the month of June, 1994. The agency defined counseling calls as those in which emotional and social support was provided to individuals experiencing distress yet the problems were not so severe as to be classified as a crisis intervention call. Of the 4,200 calls received by the agency in the month of June, 1994, 520 were classified as counseling calls. The case records of these 520 calls were analyzed for gender and age distribution, nature of calls, length of calls, and referral rates of counselors.

Return to Top

Results and Implications

Sources of Information and Barriers to Obtaining Information

The first two objectives of the project were to identify sources of information used by individuals when they are in need of help and to identify barriers to obtaining information about community services. The major findings included the following:

- The majority of individuals in need of help first seek information from family members and friends. I & R agencies were cited as the second most frequent source of information followed by the yellow pages, physicians, police, newspapers, clergy, counselors/caseworkers, and service providers.
- Approximately 10% of the respondents in the citizen survey (N = 100) were unable to identify any source of help; 23% were unable to identify more than one source of information.
- Age differences were found in the identification of the first source of help. For all youth, 100% of the respondents indicated they would seek information from a friend as a first source of help and 92% stated they would also seek information from a family member. Teenagers were less likely than all other age groups to seek information from a member of the clergy or a physician.
- Barriers to trying to obtain help from the human service system were issues of pride and shame, lack of trust, and concern for privacy.
- System barriers cited were fragmentation of services, transportation problems for those needing help, application processing delays, categorical funding, bureaucratic obstacles, and lack of available, accessible services.
- The predominant cultural barriers among Hispanic/Latino citizens was the lack of services for individuals with limited-English speaking ability and the fear of deportation.
- African-American respondents cited barriers due to lack of service providers who were
- African-American or who were responsive to the African-American community. African-American respondents said they were more likely to turn to family members, neighbors, and clergy in times of trouble or crisis rather than to service agencies.
- Lack of bilingual ability and illiteracy were reported to be the major barriers to knowing about and using human services for the Southeast Asian community included in this project. Suggestions for providing information to these individuals included working with religious leaders (Buddhist monks, the refugee resettlement program sponsored by Catholic Charities, and various programs sponsored by the Protestant churches in the community), advertising on the local Southeast Asian radio station, and disseminating materials in appropriate languages at the Asian markets in the community.
- Barriers identified by service providers and information providers were the lack of common data bases containing current and accurate information for use by all information providers, the proliferation of I & R agencies, and the duplication of services by I & R agencies with similar purposes.

Counseling Call Analysis

The third objective of this project was to analyze the "counseling" calls received by an I & R agency to determine the nature of the problem, the extent of intervention provided by phone counselors, and the extent to which counseling calls were referred to other service providers. The major findings of this analysis included the following:

- A higher percentage of females (66%) than males (34%) sought support from the telephone counselors during the period of the analysis.
- The callers ranged in age from 17 to 67. In 88% of the records, the caller was the client; in 12%, the individual was calling on behalf of a child (6%) or another adult (6%).
- The highest percentage of calls (see Figure 1) were for emotional problems (30%), problems with a child or teenager (15%), substance abuse problems (11%), partner abuse (9%), financial problems (8%), child abuse (6%), suicidal thoughts (6%), relationship problems (4%), sexual assault victim (3%), health problem (2%), homelessness (2%), and work problems (2%).
- The shortest counseling call (1 minute) was made by a client requesting counseling services for sexual abuse. He did not want to talk to the I & R personnel, although he was quite distressed. He was referred to a local Abuse Center.
- The longest counseling call (45 minutes) was made by a client whose fiancee had been jailed for drug possession. She was shocked, angry, and distressed over the situation but wanted to preserve the relationship. She was referred to Nar-Anon.
- The telephone counselors offered referrals to approximately 50% of the callers. When referrals were not made, it was because no service was available or because a referral was not wanted or not appropriate.
  Return to Top

Implications

The outcomes of this project documented that I & R agencies serve as an important entry point that can facilitate early intervention services. However, the most frequently cited information sources were family and friends. Efforts should therefore be made to ensure the general citizenry is informed of community services and I & R agency services so that individuals and families will be able to obtain help when needed. It is imperative that I & R agencies have current and accurate information about service providers and community organizations and that they be trained to disseminate this information appropriately. There is also a need for communication linkages among the various information providers to avoid duplication of effort and to reduce caller frustration in seeking assistance.

The lack of bilingual and bicultural staff is a major obstacle to seeking help. There is a need to provide a wider variety of I & R services in culturally responsive ways to meet the needs of the different ethnic populations of local communities and to conduct outreach activities to help individuals in need of service locate and obtain assistance.

I & R agencies perform an important role in providing social and emotional support to individuals in distress as well as in times of crisis. It is therefore critical that these agencies be considered to be an important component in the system of care continuum and that they be included as one of several participants in the provision of family support. I & R agencies can be an important link in achieving the goal to provide information equity among at-risk children and their families.

Return to Top

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Return to Top

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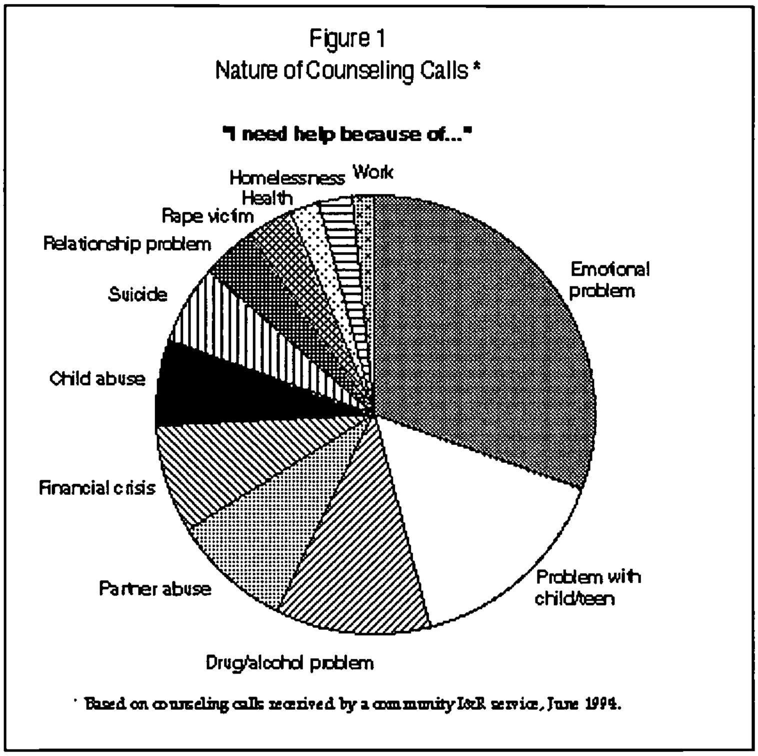
Return to Top

[Home] [Search] [Index]

Figure 1

Return to Article



[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Utilization of Children's Mental Health Services: Differentiating Families Who Use Community-Based Services from Those Who Do Not

Authors

Introduction Method Results References
Return to Table of Contents

Introduction

One of the primary aims of the Vanderbilt School-Based Counseling Evaluation Project is to assess whether school-based mental health services increase the accessibility and use of services among children with serious emotional disturbance relative to traditional community-based services. This project presented a poster at the 7th Annual Research Conference for Children's Mental Health in which the service utilization rates of the project's school-based and community-based counseling groups were reported. At that time, the utilization rates for these two groups were highly discrepant in favor of the school-based counseling group. While the participation rate for school-based counseling was 99% (91 families), that for community-based counseling was only 17% (17 families).

In an effort to increase participation among families referred for community-based services, the project has implemented several significant changes in the recruitment and referral process. Instead of paying the customary fee for service to the community mental health center, the project now pays a portion of each therapists' salary to cover those hours devoted to scheduling and providing counseling services to participating project families. As a result, the project has been successful in recruiting a total of 46 (38%) families for community-based services. The finding that the rate of service acquisition for the community-based counseling group continues to be significantly lower than that for the school-based counseling group (i.e., 85%) strongly suggests that the school-based program provides mental health services to children who would otherwise go without needed services.

Return to Top

Methods & Results

In order to understand better why some families seek community-based services and others do not, t-test comparisons were made on a number of theoretically determined variables.
No differences were found, however, on any of the following demographic variables: child's age, gender, or race; family income; education of primary caregiver; presence of a male in the household; prior use of mental health services; or the extent to which the family reported having reliable transportation.
Likewise, no statistically significant differences between groups were found on a measure of parental distress (Brief Symptom Inventory; Derogatis & Melisaratos, 1983), a measure of parent involvement in the child's daily life, or a measure of the frequency with which various strategies are used to resolve conflicts between the parent and identified child.

Since primary caregivers are instrumental in obtaining services once a referral is made, their perceptions of child functioning were expected to distinguish between those who follow through on the referral for services and those who do not. A comparison of scores on the parent version of the Child Behavior

Checklist (CBCL; Achenbach, 1991) showed a trend indicating that seeking treatment was associated with higher (i.e., more disturbed) CBCL scores ($t = -1.83$, $p = .07$). This was also the case for externalizing symptoms ($t = -1.67$, $p = .09$), but this finding did not hold true for internalizing symptoms ($t = -0.50$, $p = .61$). Likewise, parent perceptions of their child's interpersonal strengths also distinguished between the two groups. Parents who sought services for their child reported significantly fewer interpersonal strengths for their child than those parents who did not obtain these services ($t = 2.20$, $p < .05$).

In addition, scores on the Family Assessment Device (FAD; Epstein, Baldwin & Bishop, 1983) were significantly different for service utilizers and nonutilizers. Families who sought treatment had significantly lower mean scores on the General Functioning Index of the FAD than did those who had not yet obtained services ($t = 3.24$, $p < .001$). This was also the case for the Problem-Solving subscale ($t = 3.59$, $p < .001$), the Affective Responsiveness subscale ($t = 4.41$, $p < .001$), and the Behavioral Control subscale ($t = 3.02$, $p < .01$) of the FAD. Other subscales of the FAD that were not significantly different between the two groups included Affective Involvement, Communication, and Roles/Responsibilities.

In an attempt to learn why some families decided against accessing the services for which they had been referred, a Nonattendance Questionnaire was administered during the project's most recent home interview (i.e., Summer, 1994). In light of the finding that families reporting higher family functioning were less likely to access services, it is interesting to note that among the most frequently endorsed items were "I can handle my child's problems on my own," and "Children's problems tend to work out by themselves." Likewise, the high frequency with which the item "My child didn't really have a problem" is consistent with the finding that families who did not access services reported fewer problem behaviors for their children on the CBCL.

Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Children's Mental Health Needs and Services in an Urban Area: Mapping and Analysis

Authors

Introduction Method Results References
Return to Table of Contents

Introduction

Previous studies in Psychiatry have attempted to understand the influences of city life on psychopathology and development in children. For the most part, these studies have dichotomized environments into urban and rural areas with the underlying hypothesis that all urban areas are experienced by inhabitants as stressful and deleterious to their mental health. However, environmental stress is not distributed uniformly within a city&shyp;there are safer areas and less affluent areas. Therefore, wholesale comparisons of urban versus rural populations may not make sense. Mapping as a methodology offers an alternative wherein the micro-environments that neighborhoods offer can be examined with more precision. These environments can then be compared with the populations that live within these neighborhoods.

With these methodological considerations in mind, one can begin to examine how neighborhood environments are related to children's mental health and the use of mental health services. The associated hypothesis that can be examined is one that was most explicitly stated in Unclaimed Children (Knitzer, 1984): Distribution of mental health services is uneven and may be most scarce in areas of highest need. This preliminary study attempted to use mapping and statistical techniques to begin to address these issues.

Return to Top

Methodology

The setting for this preliminary study was a small city of 124,000 people located in the Northeastern United States. The median family income in 1990 was $15,000 and 31% of families were living below the poverty level. Three main concepts are defined for study: (1) mental health service use, (2) mental health service need, and (3) the ratio of mental health service use to mental health service need. An estimate of mental health service use was obtained by enumerating cases seen at a child guidance clinic. These index cases were geo-coded and plotted within census tract block groups of the city. Child protective referrals were enumerated and used as an indicator of disturbances in mental health with respect to children and families in each census tract. Federal census tract data were used to characterize attributes of each census tract block group.

In order to represent the relationship of mental health service need to service use, an index was constructed&shyp;number of cases enrolled in the mental health clinic per block group was divided by the number of child protective referrals per block group; this was done for each block group. This index was referred to as the mental health service use to need ratio. This index will be larger if the ratio of service use to service need is high. However, if there is greater need or less mental health service use, then this index will be lower.

Data for this study were gathered from one of the publicly funded child guidance clinics whose staff sees about 1,200 children per year&shyp; about one-third of the child mental health cases served in the urban center. The city was small enough in area that patients could move freely between the child guidance agencies. Data were also obtained from the state child protective service. Information from these two agencies was downloaded from the agencies' computer system to a centralized PC. In addition, US 1990 Census data and a citywide survey of vacant housing were used. Census and neighborhood survey data provide proxies to characterize the neighborhood environments.

Computer assisted mapping was done using MapInfo, locating cases within US census tract block groups. Using these data sources and techniques, data for each block group were compiled and statistically analyzed using SYSTAT.
Return to Top

Results

This study revealed that an average of two percent of the entire population who were less than 18 years of age received mental health services over a five year period. This figure compares favorably with similar surveys done elsewhere in the U.S. Maps produced from these data, however, show considerable variation within the city in terms of distribution of these services. Considering each of the 129 block groups located within the city limits, anywhere from zero to nine percent of the population received services over a five year period. Service intense block groups are scattered throughout the city and not clustered around the child guidance clinics.
In a four month period, there were from zero to fifty child protective referrals per one thousand population in each of the 129 city block groups, with an average of seven referrals per one thousand population. Again, the density of referrals per block group shows scatter and variability.
The percentage of vacant buildings offers one view of a city neighborhood. Other characteristics of a city neighborhood include unemployment rate, ethnic mix of the population, proportion of households that move, family income, and percentage of homes below the poverty level. These characteristics may be considered different aspects of urban stress. It was hypothesized that these measures of urban stress impact the mental health of the members of the neighborhood and hence are related to mental health service use and need.

In order to examine the potential relationships between these environmental factors and mental health service use and need, statistical regression analysis was used. These analyses show that child protective referrals as a proxy for mental health service need are directly proportional to the unemployment rate and the percent of the population that is not Caucasian. Mental health need as represented by child protective referrals is not statistically related to poverty levels, proportion of the population that is English speaking, proportion of the population graduating high school, proportion of the population moving into the area in the last five years, population density, or proportion of buildings that are vacant.

The amount of mental health service provided is directly proportional to the unemployment rate. In those areas with highest urban stress as measured by high numbers of vacant buildings, the amount of mental health services is also related to the number of people living in the same area for longer than five years. The density of mental health cases, however, is not related to percent of the population which is of minority status, population density (number of people/number of buildings), percent of high school graduates, percent of English speaking families, or proportion of families living in poverty.

The use to need ratio, as was mentioned above, represents the extent to which mental health problems are being addressed by services. This index provides a test of whether or not the most severely stressed areas of the city are receiving adequate mental health services, or as suggested by Knitzer (1984), whether the most disadvantaged children are receiving fewer services than less disadvantaged children. In fact, statistical analyses reveal that a high child protective referral rate is associated with a low index use to need ratio, providing confirming evidence for the hypothesis that those most in need are not receiving mental health services. A high proportion of members of ethnic/racial minorities within the population is also associated with a low use to need index. This result indicates that non-minority populations avail themselves of mental health services more than do members of minority populations.

If we consider those 15% of census tracts of the city that have higher stress as measured by percentage of vacant buildings, we discover that a high use to need index is associated with the highest percentage of vacant buildings and the highest population densities, in addition to the above findings. These findings indicate that people living in areas of highest population density and highest urban stress do avail themselves of mental health services when they need them.

What is equally important to note is that the use to need index is not related to employment, migration, poverty levels, percentage of the population that speaks English, or percentage of the population who has graduated high school. These negative findings demonstrate that when child protective referrals are high, children from that neighborhood are using mental health services, whether or not they are poor, speak English, have graduated high school, have recently moved or are employed.

These findings are preliminary, especially since they use data from only one of three public mental health clinics. Therefore, these findings need to be confirmed by additional data collection and analyses.

Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

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Addressing the Barriers to Mental Health Services for Inner-City Children and their Caregivers

Authors

Introduction Method Results Discussion
Return to Table of Contents

Introduction/Purpose

Developing the means to address barriers to help seeking is critical given that lower income, minority children are at greater risk for the development of psychopathology. This paper outlines a series of three research studies designed to identify factors related to children's mental health service usage and barriers to help seeking for urban minority children and their caregivers. In addition, this paper describes the systematic development and evaluation of a telephone intervention strategy aimed to increase overall attendance at initial intake appointments at an urban children's mental health agency. The first study explores differences in demographic variables, for two groups of children, those that came to an initial intake interview and those that requested child mental health services, but failed to come to any scheduled appointments (n=450). The second study evaluates a telephone engagement intervention meant to increase initial attendance (n=54). Finally, the third study more rigorously evaluates the impact of an intensive telephone intervention on initial attendance rates by randomly assigning families to the more focused telephone intervention or a "business as usual" telephone screening (n=108).

Return To Top

Method/Procedures

The series of studies were meant to reach the following objectives: 1) to document demographic characteristics of those children and families who requested mental health services at an urban agency; 2) to explore differences between those children and families that requested services but did not come for an intake appointment and those that came for an intake appointment;
3) to identify factors that would predict attendance at the initial appointment and; 4) to develop and evaluate a telephone intervention strategy based upon the empirical findings of previous mental health services literature.

Research Site
All three studies were conducted at the Institute for Juvenile Research (IJR), the Child Psychiatry Division of the University of Illinois at Chicago. IJR is an inner-city, child mental health agency, with 67.3% of the children living with their mothers in single parent households. Approximately, 85% of the 450 families who requested services last year were supported by Public Assistance. Almost two thirds of children seen at the agency were African American,
12% were Latino and the remaining portion were Caucasian.

Study #1
Of the 450 children who were referred to
the Institute for Juvenile Research and an intake appointment was scheduled, the following demographic information was obtained: age of identified child, gender of child, primary and secondary caregivers, presenting problem and, court involvement. These children were then tracked through the intake system at the agency.

Study #2
The next study aimed to systematically develop and evaluate a telephone intervention strategy with the primary goal of increasing overall attendance at initial intake appointments. Two master's level interns, under the direction of a clinical faculty member implemented the 30-minute telephone engagement intervention. This intervention focused on: helping the primary caregiver invest in the help-seeking process by clearly identifying their child's presenting difficulties; framing caregiver's actions as having the potential to impact the current situation; and having the caregiver take some concrete steps to address the situation, even prior to the initial appointment. In addition, the inter-vention was intended to systematically explore barriers to help seeking, both within the family and the environment. Finally, an active problem solving approach was used to develop the means to address obstacles to contact with the agency.

A sample of twenty-seven telephone intervention cases were compared to the first twenty-seven cases scheduled for intake appointments in the same month of the previous year.

Study #3
Next, in order to address some of the limitations of the previous study related to sample size and design, the investigator evaluated the telephone intervention strategy by randomly assigning 108 new requests for child mental health services to one of two conditions. In the first condition, 55 telephone intakes were assigned for a thirty minute, intensive engagement intervention with two Master's level social workers. The second condition consisted of a routine telephone screening lasting approximately 30 minutes conducted by a third master's level social worker (n=53). This screening related to the presenting problem of the child and appropriate fit for the agency.

Return To Top

Results

Study #1
Only 277 (61.6%) of the 450 children accepted for intake appointments were ever brought in by their caregiver. In relation to gender of the child, 64.5% (n=290) of all children accepted for service at the agency were male, however, only 176 (60.7%) actually came for an intake appointment. In comparison, girls were more likely to be brought to at least one appointment. Of the 160 girls accepted for intake appointments, 101 (63.1%) actually came to at least one appointment. When primary caregiver was considered, 302 children (67.1%) were being cared for by their mothers at the time of the initial call to the agency. Only 170 of these children (56.3%) were ever seen for a first interview. Children who were parented by foster care givers were more likely to come in for scheduled appointments, 119 intakes were scheduled by foster parents and 91 (76.5%) of those appointments were kept.

In relation to presenting problem, children were most likely to be referred for aggressive behavior (n=106 intakes scheduled) or ADHD symptoms (n=79). However, only 62 (58.4%) of children with aggressive behavior and 35 (44.3%) of children presenting with ADHD features ever came for an initial appointment. Children identified as having been severely abused or experiencing severe trauma were more likely to be brought to an appointment&shyp;22 appointments scheduled vs. 16 (72.7%) appointments kept. Children who did not have court involvement more often contacted the agency (n=309), but only 173 (56.0%) of these children were ever brought to the agency. Families who were involved with the Juvenile Court were more likely to follow through with a scheduled intake appointment &shyp;103 (75.2%) of the 137 intake appointments were kept.

Study #2
Results reveal that the engagement strategy increased initial appointment attendance by 29% in comparison to the more traditional telephone intake procedures. Of the intervention families, only 6 did not come to an initial appointment, in comparison to 14 no shows for the same month the preceding year. Chi square analyses revealed a significant increase in intake attendance for the intervention children and families (c2 = 5.08, p < .05).

Study #3
Of the 55 families that received the telephone intervention, 72.7% (n = 40) came to the first appointment or called at least a day prior to the interview to reschedule. Of those that underwent the more traditional screening, only 45.3% came to the appointment or called independently. Chi square analyses revealed significant results (c2 = 8.42, p < .01). Logistic regression was then used to explore contribution of age of child, court involvement, primary caregiver and gender of the child, however, these demographic variables did not add significant explanation.
Return To Top

Implications

Thus far, the telephone engagement intervention discussed above has demonstrated efficacy for increasing initial attendance by inner-city families. However, its impact in relation to ongoing engagement is still being evaluated. Further research is needed to accurately estimate the cost effectiveness of this approach and the impact that such a shift in agency procedures has on efficiency, staff morale, etc.

The foundation for any future children's mental health services research is the ability to engage children and their caregivers in services.

If clients do not access services or remain in service for a sufficient period of time, the efficacy of any mental health treatment cannot be tested. Larger research initiatives are clearly needed if there is to be an increase in quality and access to care by minority children and families. In light of the growing concern about the inappropriate use of costly, restrictive treatment for children, this paper has begun to examine issues related to increased use of outpatient children's mental health services.
Return To Top

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Return To Top

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies,
Florida Mental Health Institute, University of South Florida,1996

Referral Bias?: A Clinical Comparison of African-American and Caucasian Children Referred to a Child Psychiatric Outpatient Clinic

Authors

Introduction Method Results Discussion References
Return to Table of Contents

Introduction & Purpose

The question of referral bias is particularly relevant in children's mental health, as children rarely refer themselves. Referral source and presenting problem are particularly germane to this question of bias as they reflect who perceives what kind of problem. A critical question is whether intrinsic background characteristics of the child, such as ethnicity, affect the process of referral and evaluation for behavioral and emotional problems. In the context of the burgeoning literature on the role of cultural congruency in mental health service delivery, it becomes important to examine the issue of bias in referring minority children for services.

Building on previous studies, we were interested in examining our clinic population to explore the question of referral bias. Controlling for socioeconomic status, gender, and age, we wished to examine whether in our clinic African-American children when compared with Caucasians were:

1. more likely to be referred by coercive referral sources (e.g., courts)
2. have more severe (externalizing) presenting problems
3. have similar levels of psychiatric impairment.

Return to Top

Procedures

Subjects

The 206 subjects were taken from the total 683 clients who contacted the Child Study Center (CSC) from July 1, 1992 to June 30, 1993. Forty-eight percent of the children who come to the clinic are from New Haven&shyp;the remaining 52% are from the outlying suburbs(34%) and the rest of the state (18%). Over half of the children are Caucasian (55%), 31% are African-American, 14% Hispanic. Over 600 children are enrolled as new cases each year.

Our sample consisted of subjects who were (a) either African-American or Caucasian, (b) were referred for primarily an externalizing or internalizing problem and (c) received at time of evaluation a primary DSM-III-R Axis I diagnosis reflecting an internalizing or externalizing disorder. Overall, these 206 subjects represent 30% of clients who contacted the clinic during that year. The sample was 57% male (n = 117) and 43% female (n=89); 31% (n=64) African-Americans and 69%
(n= 142) Caucasian.

Site

The study site is a university based inner-city children's mental health clinic that accepts patients on a sliding fee scale according to the family's financial status. Contact begins with a phone call from the parent or other referring source. The intake secretary records age, gender, place of residence, school, family composition, presenting complaint(s), previous evaluations and treatments. Parents are mailed an application packet consisting of an introductory report form covering parents perception of the child, the Family Environment Scale (FES; 25), the Child Behavior Checklist (CBCL; 26), releases of information for the school, pediatrician, and previous treatment providers, a questionnaire regarding financial information, and a stamped, addressed return envelope. Once the packet is returned, the case is opened and assigned to a multidisciplinary team for evaluation.

Analytic Plan

We were primarily interested in examining characteristics of African-American and Caucasian patients. Thus, subjects were compared using chi-square analyses on a number of relevant categorical variables, including gender, age, single vs. two-parent home, urban vs. suburban residence, pay status (insurance vs. Title XIX), Hollingshead Index, referral source (coercive vs. non-coercive) and presenting problem (internalizing vs. externalizing).

We wished to investigate whether African-Americans and Caucasians differed in likelihood of being referred for an externalizing or internalizing problem, of being referred coercively, and in DSM-III-R diagnosis, which would be assessed at the end of the evaluation period. To test these hypotheses, we again utilized chi-square tests. To examine whether groups differences existed on a parent report measure of symptomology, the CBCL, and a therapist measure, the C-GAS, ANOVA's were conducted with ethnicity as the independent variable. To understand the relationship of ethnicity to presenting problem we utilized log linear analyses to control for gender, SES and coercive referral.

Return to Top

Results and Implications

When we compared African-American and Caucasian patients we found no differences in gender or age. However, a significantly higher percentage of African-Americans came from the immediate New Haven urban area as compared to Caucasians (80% vs. 17%). In addition, significantly more African-Americans came from single parent families (82% vs. 55%) and were on Medicaid (75% vs. 38%). Compared to Caucasians, a greater number of African-American patients appeared to be disproportionally distributed in the lower SES brackets of the Hollingshead (Classes IV, V; 71% vs. 46%).

At the time of intake, African-Americans were almost 3 times more likely than Caucasians to be referred by coercive sources (61% vs. 22%). Also, African-Americans were significantly more likely than Caucasians to be referred for externalizing disorder at intake (88% vs. 67%). Of the children who presented with externalizing behavior, 55% of the African-American children were referred by coercive sources, compared to 15% of the Caucasians.

When African-American and Caucasian children were compared on the CBCL, more African-American parents reported externalizing symptoms ($p < .05$). However, this difference was no longer significant when we controlled for SES. African-American and Caucasian children were not rated differently on the internalizing scale.

On a therapist rated measure of global functioning, the C-GAS ratings for African-Americans and Caucasians did not differ significantly. There was no significant difference in the proportion of externalizing or internalizing diagnoses between African-Americans and Caucasians.

Eighty-eight percent of African-Americans were referred for an externalizing problem, and 12% for an internalizing problem. At the completion of evaluation, however, 50%

received an externalizing diagnosis and 50% an internalizing diagnosis. Similarly, 67% of the Caucasians were referred for an externalizing problem, 33% for an internalizing problem; at evaluation 36% of this group received externalizing diagnoses, and 64% internalizing diagnoses . Log linear analysis was utilized to examine the relationship between ethnicity and reason for referral while statistically controlling for SES (I-III vs. IV-IV), referral source (coercive vs. non-coercive) and gender, as well as, the interaction of ethnicity and referral reason. Results indicate that once the variance attributable to these variables was partialled out, that African-American children were still more likely than Caucasians to be referred coercively (Z = 5.08, 12 < .0001), and more likely to be referred for an externalizing rather than an internalizing disorder (Z = 3.93, p< .0001).

Return to Top

Discussion

In our study, the African-American children and adolescents were primarily from the city, from single parent families, socioeconomically disadvantaged and likely to be coercively referred for an externalizing problem. In contrast, Caucasian children and adolescents were likely to be from the suburbs, insured, from two parent families and to be non-coercively referred for an evaluation. However, their diagnoses indicated similar levels of psychiatric impairment. In our analysis this held when we controlled for gender and SES for the African-American group. The findings in our clinic corroborate those of other studies. Compared to Caucasians, African-American children, despite a similar clinical profile were at greater risk for coercive referral and for externalizing presenting problems.

One speculates, with other authors, about the perception of African-Americans by referring agencies. Fabrega and colleagues (1993) observe that "social systems appear" less tolerant of AfricanAmericans and hence their group may be "selected for," in that the social system compels them to obtain (not select) care (p. 412). This interpretation is supported by the finding discussed above. These authors question the assumption that minorities avoid seeking psychiatric help, resulting in delay in obtaining needed service. They suggest the opposite&shyp;based on their findings&shyp;that AfricanAmericans may be "shunted" to psychiatric service earlier than Caucasians as a result of more surveillance and discomfort on the part of social agencies. Takeuchi and colleagues (1993) suggest a labeling perception on the part of social service agencies. However, they identify poverty, rather than race, as the identifying characteristic which elicits labeling. Since most of the African-American children seen are poor, there is more likelihood that they may be referred by the myriad social service agencies with which they have contact. Although our findings point to similar conclusions, our results were not altered when we controlled for SES. Hence, this tentatively suggests a more general referral bias that goes beyond socioeconomic disadvantage.

Of the possible explanations for our findings, referral bias seemed the most plausible given the results of this study and previous research; however, the role of ethnicity and race in psychopathology is complex and poorly understood, and this conclusion is tentative. Further research controlling for factors such as socioeconomic status is needed to examine relationships between ethnicity and psychopathology and the presence of bias in mental health services.

Return to Top

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Return to Top

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Return to Top

[Home] [Search] [Index]

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New Approaches to Evaluating Systems

Author

The Need to Reinvent Evaluation Creating Systems Change
Building a System of Accountability What Will Change Mean?

Return to Table of Contents

We are all struggling with systems change and how to create knowledge development strategies that will inform our efforts to develop better systems of care for children and families. It is important, now more than ever, that we learn from each other in terms of reinventing evaluation. I propose that we follow a model of co-learning &shyp; the co-learners in this instance being those who are trying to effect change and those of us who are evaluating them, or as I like to think, informing them as they do their work and develop reflective practice. I would like to make three observations about co-learning.

First, with this "co-learning model" comes a different relationship with the people we serve; it is no longer an expert and a subject, or the researcher and the researched. We cannot underestimate the difficulty of becoming co-learners, or the change that it means for all of us, at both ends of the co-learner relationship.

Second, we need to reinvent evaluation, or knowledge development, so it becomes an internal part of doing business in our large systems. Evaluation needs to be part of the process to illuminate support and assess our actions as we craft our services for children and families. When it is internalized, it is no longer out there being done to us, but instead is in here being done with us.
Third, we have to recognize the partner who has always been there, and that is the public. We are in an era, which I think of as "the new social policy," in which public accountability has come to the forefront. So, another constituency or stakeholder in the co-learning process is the public, and we need to reflect on the "public will" that we must generate to maintain the service structure, redesigned or not.

My colleagues and I are learning from actual evaluations of systems change and from the risk takers who are trying different evaluations strategies. In addition, we just started a new inquiry for understanding process studies. The convention is that you cannot undertake an evaluation without doing a process study. So we have been using our evaluation databases of both comprehensive programs and system reform efforts to understand what people mean when they talk about process evaluation.

Return to Top

Creating Systems Change

We have identified some of the earmarks of systems change, the contours of emerging practice, and the challenges that come with efforts to do evaluations differently. I want to argue that we cannot do systems change unless we also build in the knowledge development strategies that inform change, as well as assess it.

In the child and family arena, we have said that simple programs and categorical approaches are not enough and that we need systems change. We have said that we have to develop systems that provide a set of services, preventive and otherwise, to children and families. So across the board, we bought the notion of systems reform, in part because we know what we have does not work &shyp; not because we know what the shape of the system reform looks like.

That puts us in a particularly difficult position because we are inventing the system as we implement it. Systems change involves many actors and reconfiguring so many different things, that we are talking about creating a very, very complex entity.

We know that our comprehensive programs have not worked, not least because we cannot scale them up. We have spent the last ten years watching the family support arena evolve from a fairly simple set of programs into more comprehensive systems. This has led to a growing realization the family support initiatives are context-dependent, that comprehensive efforts require linkage to other services families need, and that no single agency can adequately honor a holistic approach to families. We know we have to build linkages, collaboration, and coordination.

Our landscape, however, is full of programs and some systems change initiatives, that demonstrated, researched, and died. The challenged, then, is to sustain and scale up these initiatives &shyp; something we do not yet know how to do. These efforts bring us instantly into a political context that has to be honored-again, this comes back to the issue of "public will." We must create knowledge and accountability that will warrant public faith in what we are trying to do.

Return to Top

The Need to Reinvent Evaluation

We can start by building our case on evaluations of CASSP and, other, usually single system, reform initiatives that suggest systems reform is possible. Currently, we are at the same point in evaluation as we are in systems reform. We need to recreate and rethink what we do, but it is not clear what the path ahead looks like. Change will require a willingness to take risks, and feedback through a co-learning model so we can revise our evaluation practices, as well as our program practices. Hence, we have to reinvent evaluation and knowledge development, so that they become features of systems reform that work hand-in-hand with the effort.

Systems reform is difficult, and requires much of evaluators. The goals of system reform include the major restructuring of existing services. We need to rethink and redirect public resources and public services into a coherent system. This cross-system effort should look at the needs of an entire community, not simply particular population groups. It also should involve service strategies that are different, those that go beyond the coordination of existing services and create a new system that is integrated and user-friendly. It should be a service system that operates differently, and looks and feels different to families who are using the system. We must involve multiple stakeholders in these efforts, including program participants, front-line workers, managers, and those who decide how resources are allocated in communities.

Additionally, we need to build accountability into the resource allocation process. This means creating responsive governance entities that can manage accountability and design different financing strategies. We cannot underestimate the risk, complexity, and challenge that accountability poses with multiple stakeholders at the state and local level in systems reform.

We need to demonstrate that systems reform is productive, that it can be implemented, that it produces important outcomes, and that it is better than alternative approaches to organizing and delivering services. With this comes a need for internal validity, high quality evidence, and external validity, so that this evidence is useful not only to evaluators, but to other stakeholders as well. We need to inform program development, build and sustain the public will, and enlist a high degree of participation to make the overall system work.

These are enormous challenges to address, particularly in the context of the new social policy. Under the new Congress we are going to have more and more decentralization, more and more block granting, and fewer and fewer entitlements. We are going to have a very different look in states and communities around the country. There are new players and new stresses. I think there will be incredible competition for increasingly scarce resources.

Return to Top

What Will Change Mean?

What does this mean for those of us who have been laboring in the vineyards of systems reform? I think it means we have to redouble our efforts and confront a number of challenges. A couple of years ago the governor of West Virginia set up a new cabinet for children, youth, and families that aimed to decentralize planning and decision making about the use of resources for children and families in the state. The cabinet gave money to a number of communities around the state and asked an array of players to participate. They were told that they would have control of much of the existing revenue, and they had to plan a new system which met everybody's needs, underscored prevention, and also made it possible to access the kind of treatment that some families would need.

These communities had to plan, implement, and assess the effectiveness of their efforts. They were scared to death and very much felt they did not have the kind of information they needed. They went out and collected some demographic data, but realized that it was necessary, but not sufficient. They then started doing surveys, focus groups, and so forth, to get the input they needed for planning this new system of services. When it was time to evaluate their efforts, they were terrified. They could not find an evaluator who would come in, especially with their very scarce resources, to help them perform a participatory evaluation.

This, I think, is the reality in many, many communities. We decentralize and say that we are empowering communities, but we give them disempowering evaluations and fail to make them stakeholders in the entire process. I think we need to come to grips with this as we reinvent evaluations.

What are some of the contours of the new evaluation practice? We need to move beyond experimental research design. Much of our practice, particularly as it has been played out at the highest levels of government, says that there is no knowledge past random assignment. We need to build a case for developing other methods that are stringent and that provide useful knowledge, above and beyond what can be achieved through an experimental research design. There are questions about the ability to implement, pure and simple, an experimental research design in systems reform efforts. Usually when one does experimental research design, it is with a program.

There is a specified treatment, an external evaluator. From this we determine whether something works or not&shyp;usually not "how" something works. In experimental research designs, we make a whole set of assumptions about research validity and "treatment," which I think are not possible to guarantee in systems reform efforts.

As I have looked across the terrain in the 20 years that I have studied programs for children and families, I have not seen any examples in which a well-done evaluation, meeting the conventions of experimental research design, has resulted in any kind of significant program expansion. I have increasingly come to think that, in the social services arena, these evaluations create reasons why we don't do things, as well as inform what we do.

We need to ask what we need to prove, to make a plausible case, that some new initiative is working. We need to identify alternatives to experimental research design, and ask the question at the community and state level, "who are the stakeholders, what is proof, and what's a plausible case that says that systems reform works?"

People like me argue that we need alternatives to conventional practice. In fairness, I am asking you to open up a Pandora's box of problems. The more we look at alternative practices, the more I see comfort in the traditional recipe for doing conventional research using experimental design with an experimental evaluator who is the expert, assumes control, and so on. What does evaluation as a helping relationship really look like? It means that the role of the evaluator is fundamentally different, and it means a lot of stress and tension as we try to redefine this helping relationship &shyp; the co-learning model, if you will. It means we are in a context with different stakeholders who have different expectations for what we are going to do. Part of the co-learning model is thinking through those different expectations and somehow working out a reasonable way of proceeding in the face of them.

I know it is not "going native" as they say in anthropology, and becoming completely the voice of the program. I know it is not being remote and disconnected. The answer lies out in the middle, in unexplored territory, particularly against the backdrop of a group of stakeholders who have different ideas about objectivity, bias, and the rest of it.
Return to Top

Building a System of Accountability

What does it mean to build a system of accountability? It is very different than building a good evaluation and knowledge development strategy. Accountability is when you learn and see how you are doing. You also generate stakeholder involvement so there will be an audience who will listen to what you have found, who will then have the responsibility for problem solving, and when necessary, pulling the plug when something is not working. This is a different game than evaluators have been in before. There is an emphasis on problem solving and midcourse correction, but there also the notion of "plug pulling" that we may not have faced in the way we will need to in this new social policy environment. It also means figuring out the rewards for success for risk takers.

We also need to understand the process of developing systems change initiatives. Some of the work by the late Judy Gardner and her colleagues at the Heller School at Brandeis suggests that systems reform efforts build on one another &shyp; that CASSP created the infrastructure on which the Robert Wood Johnson Mental Health Services for Youth Initiative was able to build. We need to get the historic dimension, and get a sense of the infrastructure of systems reform, document that, and extract the lessons for others. One of those lessons may be that systems change takes time.

With this new understanding of process comes the notion of mixed methods, and getting beyond what we call anecdotes for "correlation coefficients." We've been looking at process studies and are amazed at how many of the process studies embedded within evaluations are about "parallel play." The correlation coefficient is over here, and the case study that demonstrates that is over there. There is really a need to connect these two methods so they work together, complement one another, and produce knowledge that cannot be generated from a purely quantitative or a purely qualitative strategy.

We need to spend more time in training and capacity building for evaluators. One of the things we hear is how few evaluators there are who have the negotiation and other skills necessary to work in these new ways, in this co-learning model. As evaluators, we need to examine how we are training people in these skills that will be requisite, and how we can get this training in place. It may require developing apprenticeships with innovative evaluators that enable the next generation to learn from the experience and the struggles of this first generation of risk takers.

There are a set of earmarks for this new framework for evaluation. First, this new strategy must develop the internal capacity to collect, analyze, interpret and utilize a wide variety of data. It must incorporate knowledge development as one of the central functions of systems reform itself.

Secondly, the work is never done. When we develop a system, it has to be one that is continually reinventing itself as circumstances change and as the needs of children and families change. This capacity for continuous self-reflection an important element. We must use information to inform a wide variety of stakeholders, and build consensus about the outcomes we want and the strategies we will use to improve those outcomes. Finally, we must use information to build and enforce a sense of public accountability for this process.

When we looked at examples of people who have been trying to do these strategies, we found four types:

- Mixed methods strategies, in which people are using quantitative data and simultaneously talking to communities and trying to get participant perspectives on implementation and the value of programs;
- Knowledge development and self-evaluation strategies, which Bob Illback has done in Kentucky, and which Lynn Usher has done in the family resource centers in Maryland, as part of the Maryland Service Reform Initiatives;
- Public accountability, which is the outcome-based accountability strand, which you see a great deal of, particularly in the United Way Success by Six initiatives; and finally,
- More participatory strategies which are more in line with some of things I've been suggesting.

We have learned several lessons from trying these new approaches. One is that it is incredibly difficult to promote organizational learning and the capacity for reflective practice. Those difficulties lie both in our stance as evaluators and in the receptivity and structure of the organizations we're asking to become learner organizations. There's a recent article in Evaluation Practice that talks about how few instances there are where organizations have really learned from evaluation. A profound change in organizational culture is necessary if we are going to implement these new evaluation approaches.

We've also found that it is a real struggle getting trained evaluators for this organizational development approach to evaluation. They are simply not there, and when they are there, they require time and resources, including money, to implement this kind of practice. More self-evaluative, participatory approaches mean time on the ground, working with front line workers and managers who are collecting data, asking them about how they use that information to inform practice, to inform the multiple stakeholders in the community, and to be accountable. We cannot underestimate the time and resources that are necessary to make this work.

I would argue, however, that if we do not open the Pandora's box of these new frameworks for practice, we will be stuck in a situation where there are fewer and fewer resources and more public distrust of our efforts. Our evaluation project at Harvard Family Research Project is trying to create a broader forum for our risk takers. We have launched our newsletter, The Evaluation Exchange, which is meant to be a place where people who are trying new approaches can get some visibility for their work and get feedback from what we hope will be a growing leadership. We are embarking together down this road of trying new strategies, and we need to be co-learners in sessions such as this, confronting challenges of inventing and implementing this new of practice.

Return to Top

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Return to Top

[Home] [Search] [Index]

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Outcome Accountability and System Reform: What Should They Mean in Policy and Practice?

Author
Changing our Response Setting Parameters
Remarks by Discussants
Return to Table of Contents

Today I am going to discuss with you three themes in the current move to outcome-based accountability in systems reform: The first is the current political demand for improved outcomes; the second is the way we need to change our responses if we are going to improve outcomes, and third, is the way we must set parameters upon which to judge our efforts.

The Demand for Improved Outcomes

In today's political climate, policy makers have discovered outcomes and they want to use them on us. There is increasing recognition that too many children and families are not succeeding and growing rhetorical acceptance that the characteristics of the current service systems&shyp;categorical, reactive, fragmented, arbitrary, hierarchical, deficit based, coercive &shyp;do not provide a good match between what families need to succeed and what systems offer.

The growing use of today's new service mantra&shyp;"family-centered, neighborhood-based, community-designed, preventive, partnering, flexible, comprehensive, asset oriented, voluntary"&shyp;suggests how services have to change to provide a better match and what is needed to succeed.
Belief in this new service mantra requires new accountability that is not based upon adherence to procedures but rather upon success in attaining results.

Increasingly, outcomes are seen as an integral part, and in many respects, a driver of system reform. System reform can be conceptualized as requiring integration of new forms of governance, new approaches to services, new financing systems, attention to leadership and professional development, and clear enumeration of outcomes and means to hold systems accountable to meeting them.

At the state and community elected official policy making level, officials want something "that works" to reduce teen pregnancy, infant mortality and low birthweight, school unreadiness, crime and juvenile delinquency, and low skills, school dropout, and idleness. These officials are not necessarily naive, but they want to put the pressure on bureaucracies and service providers for solutions and for fixing what advocates and reformers say is broken. "You want flexibility, we want results."

Return to Top

Changing our Response

If we are going to improve outcomes (and to succeed with children and families current systems will fail), we need to change our responses at several levels. I've proposed a conceptual framework to view needed comprehensive service reforms.

The "simple model" depicted in Figure I generally produces a constellation of outcomes that are multi-dimensional, spanning health, developmental, social, and psychological dimensions.

The charge to implementers is to improve all these outcomes at a community-wide level. This requires change, particularly as it is related to eliminating the categorical deficits of the old system and replacing them with the service mantra of the new.

Some of the positive outcomes for children, which are generally consistent with what community or state stakeholders want to produce include:

- Success in school
- Responsible sexuality
- Social consciousness
- Community involvement
- Healthy lifestyle
- Readiness for adulthood

Policy makers often stop here and turn the responsibilty for improved outcomes over to implementers. These can be considered an interrelated constellation not amenable to fragmented, categorical responses. These outcome indicators are adapted from Lisbeth Schorr's "minimalist list."
What we need to ask is: 'Can these long-term outcomes (the British use the term "final" outcomes) be used to guide reform?' 'Can they be used to hold systems accountable?' 'Can they inform how different aspects of our needed and complicated array of services and supports must change?

The answer is yes and no. They can be used as a guide to creating pressure for reform. At the same time, we need different, intermediary or proximate, levels of outcomes or outputs to use for accountability and course correction purposes, applicable in different ways to different parts of the system of community supports and services.

I've proposed a formulation of three conceptually distinct, but interrelated, outcomes or outputs needed to expect changes in those long-term goals: the whole village approach, effective frontline strategies, and productive service systems. I will describe the importance of each, and then touch on ways that one can measure them.

Whole Villages. The most common frontispiece to a task force on systems change through comprehensive services is the African proverb, "It takes a whole village to raise a child." Note that it does not say that "it takes a multidisciplinary team with integrated case management to raise a child."

In distressed and disinvested neighborhoods, however, there often is a threadbare community fabric offering little support and opportunity to help families grow and develop. The challenge raised by the proverb is really, "How do you make whole villages, or make existing villages whole?"
There exists substantial empirical literature that living in distressed and disinvested neighborhoods constitutes a major risk factor to healthy growth and development. Various formulations incorporating these village factors into reform strategies have been offered: Cataldo and Hawkins and others have marketed them as "protective factors;" Chapin Hall speaks of them as "primary services;" Putnam and others describe this as "social capital;" and Public/Private Ventures speak to them as "core concepts."

One enumeration of these community elements or factors in child success can be described as:

- Social and economic stability,
- Safe and stable neighborhoods,
- Nurturing and mentoring adults,
- Positive peer attitudes,
- Diversity of "social capital" &shyp; school, church, neighborhood, civic activities, and
- Opportunities to realize aspirations.

Does this list make sense? Clearly, where these do not exist in a neighborhood (whatever other services are provided), children are not likely to succeed. Where they do exist, most children do pretty well.

Developing strategies to construct such core elements represents a challenge that must be met if the final outcomes are to be achieved. We're in our infancy of exploring how to do that. At the policy level, recent proposals to offer Midnight basketball to deter juvenile crime is a good illustration.

While we may not have answers on how government can be a catalyst for the creation of "Caring communities", we can develop metrics that do a reasonable job of measuring each of these conditions. Some approaches, most notably family support centers and settlement houses, seek to construct this village as well as work with individual families. There are outcome measures or indicators that can be tracked to determine whether communities are rebuilding, as this more detailed iteration of whole village concept for to child and youth suggests.

Effective frontline strategies. The second change that needs to occur is in frontline service delivery. How do we measure, and hold accountable, this new service mantra frontline approach that is individualized in its response to families, given that families are messy units of analysis and do not fit comfortably within regression equations?

First, we should have process measures to determine whether services actually are community-based, individually-tailored, asset-oriented, and comprehensive, which in itself is a major task. I talked with a collaborative leader enamored of Lisbeth Schorr's book, Within Our Reach, whose solution was to beat workers over the head with it until they agreed to practice exactly what she said. This service mantra is easier to enact into policy and agency mission than it is to create in practice.

With outcomes, however, I believe we must develop means to determine whether individual workers are making progress with families. Without this, broader accountability will be impossible&shyp;with it, that accountability may be complex but is at least technically possible. The following characteristics of effective front line interventions adapted from my paper in the National Center for Service Intergration Brief, Making a Difference, suggests different levels of examining such service approach outcomes at the frontline level:

- Identify Appropriate Families (Service Penetration),
- Engage Families,
- Aid in Family Growth,
- Connect to Community-Building, and
- Produce Changes in Other Systems.

This can provide a discipline for programs involved in this admittedly "mushy" family support/frontline practice. This is critical to do, because the initial gains with families may be quite removed from long-term community outcomes.

For example, let me illustrate some of the steps families in Iowa's Way to Grow program took and contrast them with the community outcomes that funders attached to the program. This comparison indicates that the relationship between what steps families take and what long term outcomes policy makers seek usually is not linear or direct (See Table 1).

Productive Service Systems. The third issue in developing positive outcomes addresses systemic responses-&shyp;raising issues of collaboration, referral, and integrated activities. We still need expertise and professional service responses-&shyp;but we need them to practice differently and connect better with one another.

Suggested outcomes we want to see from changes in the manner in which our systems respond to families might include:

- Seamless and coordinated response,
- Integrated into community life,
- Timely response to opportunities,

- Sufficient to meet objectives,
- Efficient in meeting objectives, and
- Adaptive and learning objectives.

Again, these are based upon common sense notions of where our current systems often fail to respond adequately and appropriately. They are based upon what we believe, from both theoretical and clinical roots, systems need to do to respond productively to children and families.

These system outcomes or outputs can be measured as well&shyp;often even at a performance tracking and management information system level. In child welfare, for instance, the implications of such an approach to permanency planning would be that a premium would be placed on more immediate response, minimizing disruption and retaining connected with family the these when placement occurs, and establishing the expectations for everyone in the system to achieve permanency. This is in dramatic contrast to the usual business in child welfare of placing a child, breathing a sigh of relief, and beginning the process of assessing reunification potential only as the court review date approaches.

There is nothing terribly profound in all this. It seems to me that positive final community outcomes logically must be dependent upon whole villages, effective frontline approaches, and productive service systems. The absence of any diminishes the ability of all to reach those outcomes. Think of it as basic common sense. In fact, our Iowa Kids Count book is entitled "Reinventing Common Sense" to signify how remote our systems often seem from basic principles of how children and families succeed.

Return to Top

Setting Parameters

If we want outcomes to be our friend, we must convincingly set out the parameters upon which our work should be judged.

What I talked about is not the answer that elected officials want to hear. It is not a single program or service that lends itself to sound bites or produces impressive results before the next election. At the same time, however, although elected officials live in the electoral world, they also know that these are tough issues and they want solutions, even if they are complex and long-term. What they need is clear talk on what to expect and what it will take.

We must make a case for "scale." Strategies must be adopted at a scale sufficient to influence outcomes on a community-wide basis. Returning to the conceptual framework I presented earlier, we must make the case that sufficient resources must be devoted to the strategies that, if they work, they will succeed with a large enough number of families and children to produce change in long-term community outcomes.

We must not leave parts of the puzzle out of the picture. We must be clear of what we can, and cannot do, particularly if we are not going to address community disinvestment and seek to make villages whole. We will experience intervention "fade-out" if the context in which families take steps remain hostile to future gain.

We must place appropriate expectations regarding timeframes. The Perry Pre-School Project has been widely regarded by policy makers as sound evidence that high quality pre-school programs are cost-effective. Yet our return on investment is a decade-and-a- half down the road. Patience is needed, if generational effects take a generation to occur. We must create realistic political expectations; you cannot force generational effects into a two-year election cycle window.

We must present issues of cost in context . In Michigan over the last two decades, spending on housing prisoners has increased from 3 % to 14 % of state spending&shyp; approximately $1 billion increased share of the total budget. That would fund a lot of family support and community-building services which might have done far more to protect the safety and well-being of Michigan residents than housing 35,000 more prisoners.

Ultimately, we must change our own efforts when they do not produce the intermediate or proximate outcomes that we believe they need to produce to achieve success. We do need to learn by doing, and if we take risks we will have failures. The challenge is not to institutionalize them but to learn from them to eventually succeed.

Return to Top

About Charles Bruner

Charles Bruner serves as Executive Director of the Child and Family Policy Center, a nonprofit organization established in 1989 "to better link research and policy on issues vital to children and families." He holds an M.A. and Ph.D., in political science from Stanford University.
Through the Child and Family Policy Center, Bruner provides technical assistance to states, communities, and foundations on child and family issues and heads the technical assistance activities of the federally-established National Center for Service Integration. Bruner also has served as a consultant to the Annie E. Casey Foundation in developing its Family-to-Family Initiative, its strategies for state-level systems reform, and its evaluation grants project.
Bruner has written widely on public policy approaches to developing more comprehensive, community-based responses to children, family, and neighborhood needs.

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Return to Top

Remarks by Discussants

Mary Telesford, Federation of Families for Children's Mental Health, Washington, DC.

After hearing Dr. Bruner's remarks, I also like to re-emphasize the need for strength-based models of service delivery. Too long we have emphasized the deficits of our communities which so often reinforces the negative outcomes we've come to expect.

Let me tell you about some of the strengths that impoverished communities do have, and that researchers need to recognize and work with.

1. Churches are community institutions that often know the history of what's happened in a neighborhood and have the ability to organize constituencies;
2. Community-based organizations also have a tie to a community's history, proximity to the people and knowledge of culturally relevant issues; and
3. Schools can offer access to many communities and families and can provide a neutral meeting ground.

From my recent work (unclear reference) we've been able to observe the following pattern among women of color who live in impoverished circumstances and are successful.
Foremost, they provide a spiritual base for their families and maintain a strong support system. They also maintain personal sobriety and do not use alcohol or illegal substances. They have meaningful

employment and value education, even if it has been delayed or interrupted.
Clearly if we want to build successful communities, we need to build upon strength-based models and reach out to the people and families we serve.
We need to understand what families want, which is:

1. to receive support when they need it,
2. to have a single place for services&shyp;a one-stop shop, instead of the myriad service systems they face; and
3. to receive recognition for their efforts.

If we can help families and recognize their strengths, then the outcomes will take care of themselves.

Cliff Davis

Chief, Office of Children's Services and Prevention, Ohio Department of Mental Health

I'd like to add, within the context that Dr. Bruner described, one piece that is important to our understanding outcomes achieved from the helping process.

Regardless of the theories you have been trained in or the therapeutic tools you use with the persons who come to you for help, the only thing we know for sure is that the quality of the relationship between the person receiving or seeking help and the person offering help is a key to what kinds of outcomes are achieved.

I am a therapist by trade, have spent much of my career as a community-based family therapist, and I know I did many good things&shyp;I know intuitively, instinctively&shyp;my wife could tell by looking at me whether the work I had done that day felt good to me.

Regardless of the type of indicators we talk about, we are still a long way from being able to define or articulate this important relationship quality for people who are involved in the helping process. Until we are able to work together to understand, articulate, and measure (if we have to), that relationship and its components, we still aren't really going to understand what it is that we need to be training, and what it is we have to be doing in order to achieve positive, successful outcomes for our kids and their families.

As we build processes to try to measure, understand, and articulate how we are affecting children and their families, we have to start with the families and front line workers. We have to work hand-in-hand with them throughout that process and ultimately the measure of our success will be determined by those families and front line workers.

It does no good for me to sit in the state office tower in downtown Columbus, in central Ohio, and establish outcome measures that ultimately determine whether or not my system is successful. It has to start through focus group discussion, and implementation of participatory processes with families and front line workers; they have to be integrally related throughout the whole process and it is up to them to interpret the results. We need to create the mechanisms that allow this to happen.
In the context of all the different community factors that Dr. Bruner described, asking families and workers to help us strikes me as one of the keys, at least in the mental health system, of the work that we are doing. I had compiled a list of real life kinds of indicators&shyp;I suspect everyone in this room could generate a similar kind of list. We need to pay attention to those things that our families, our kids and our front line workers say are the true indication of what our system is doing.

About the Lecture Series

The Gwen R. Iding Brogden Lecture Series was established as a lasting tribute to a citizen advocate. For more than 20 years, Ms. Iding Brogden championed the creation of high quality mental health services in local, state and national arenas. The Lecture series features national speakers known for significant contributions in the area of children's mental health policy. For more information, contact Larry Schwartz at the Department of Child and Family Studies, Florida Mental Health Institute, University of South Florida, 813/974-4641.

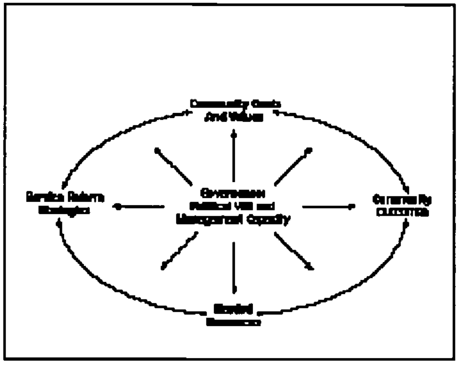
Return to Top

[Home] [Search] [Index]

Figure 1

Return to Article

Conceptual Framework for Comprehensive Service Reforms



[Home] [Search] [Index]

Table 2
Return to Article

Table 2

"Whole Village" Keys to Child, Youth Success - Existence of Public Goods and Opportunities

Stable environment for families, socially and economically

- adequacy of housing stock
- reasonableness of rent
- mobility rates
- employment opportunities
- availability of general public goods (transportation, retail goods, recreation, etc.)

Safe neighborhood and community

- crime
- environmental conditions (lead paint, abandoned buildings, etc.)

Nurturing relationships with adults

- parental participation in school life and activities adult participation in developing and supporting child and youth activities
- places known by community as supportive learning environments (e.g. family centers)
- array and supply of quality child care arrangements
- schools as safe and supportive places for children

Involvement in positive peer activities

- participation levels in youth recreational activities, numbers and diversity
- supervised play areas, parks, and events

Diverse connections with community&shyp;school, church, neighborhood, civic activities

- public library usage
- church membership and activities
- youth-based organizations
- community recognition of youth in events and activities
- voter registration and participation

Realistic opportunities to realize! aspirations

- business sponsorship of employment-education connections
- diverse choices to excel and succeed in and out of school
- positive climate and attitude among residents toward achieving potential

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