DOCUMENT RESUME

ED 426 526 EC 306 959

TITLE	Evaluation Efforts within States and Systems of Care. Chapter 1.
PUB DATE	1996-00-00
NOTE	60p.; In: A System of Care for Children's Mental Health: Expanding the Research Base. Proceedings of the Annual Research Conference (8th, Tampa, FL, 1996); see EC 306 958.
AVAILABLE FROM	Web site: http://lumpy.fmhi.usf.edu/CFSroot/rtc/proceeding8th
PUB TYPE	Reports - Descriptive (141) -- Speeches/Meeting Papers (150)
EDRS PRICE	MF01/PC03 Plus Postage.
DESCRIPTORS	Adolescents; Children; *Delivery Systems; *Emotional Disturbances; Evaluation Methods; Integrated Services; Intervention; *Mental Disorders; *Mental Health; Program Evaluation; State Legislation; *State Programs; Student Evaluation; Systems Approach; Urban Education

ABSTRACT

This collection of papers presented at a 1996 conference on children's mental health focuses on program evaluation efforts within states and systems of care. Individual papers have the following titles and authors: (1) "An Overview of State Public Mental Health Programs for Children with a Serious Emotional Disturbance" (Pamela C. Roddy); (2) "A Developmental Analysis of Neighborhood Governance: An Aspect of the Annie E. Casey Mental Health Initiative for Urban Children's Evaluation" (Marvela Gutierrez-Mayka and others); (3) "Promoting Evaluation of Systems of Care: Stakeholder Needs and Technical Assistance Strategies" (Susan Flint and others); (4) "The Comprehensive Services Act: First Year Implementation Assessment" (J. Randy Koch and others); (5) "Access Vermont: A Statewide Evaluation of Non-categorical Service Delivery to Children and Families--Meeting Community Needs, Measuring Outcomes" (Jennifer Taub and others); (6) "Conceptualization and Initial Development of the Ohio Scales" (Benjamin M. Ogles and D. Kevin Gillespie); (7) "Impact of the Child and Adolescent Service System Program in California" (June Madsen Clause and others); (8) "Evaluation of the California Implementation of the Child and Adolescent Service System Program: A Review of Documents" (Karyn L. Dresser and others); (9) "Issues in Implementing a Randomly Assigned Study Design in a Community Setting: Lessons from the Vanderbilt/Stark County Evaluation Project" (Jon Thomas and others); and (10) "Evolutional Changes in a Local System of Care for Severely Emotionally Disturbed Children and Adolescents: The Pendulum Is Swinging (Stanley Mong and others). (Individual papers contain references.) (DB)

8th Annual Children's Mental Health Research Conference Proceedings. Chapter 1. Evaluation Efforts within States & Systems of Care.

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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

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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.

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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.

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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.

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Table 1

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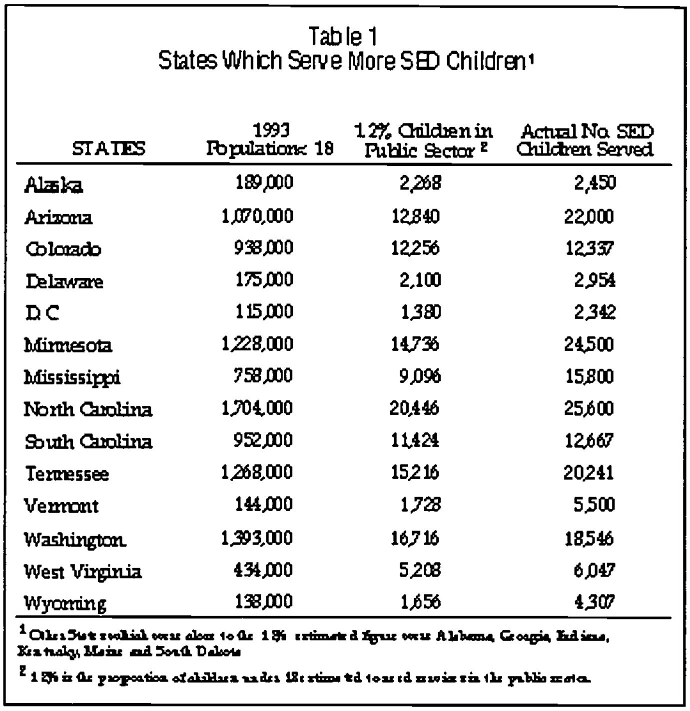

Table 1
States Which Serve More SED Children[1]

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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Table 2

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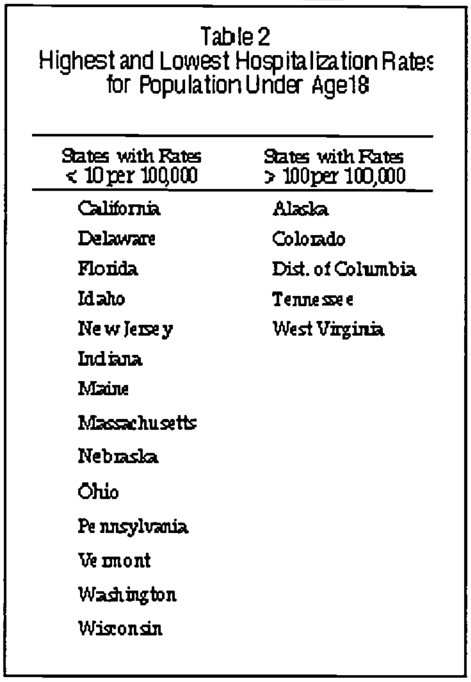

Table 2
Highest and Lowest Hospitalization Rates
for Population Under Age 18

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	

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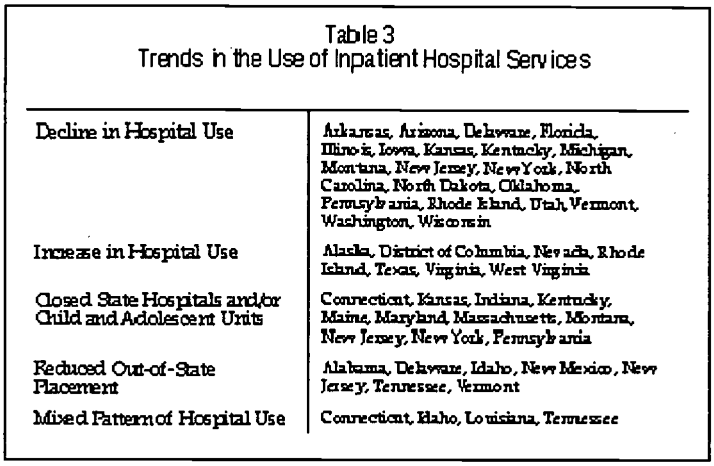

Table 3
Trends in the Use of Inpatient Hospital Services

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

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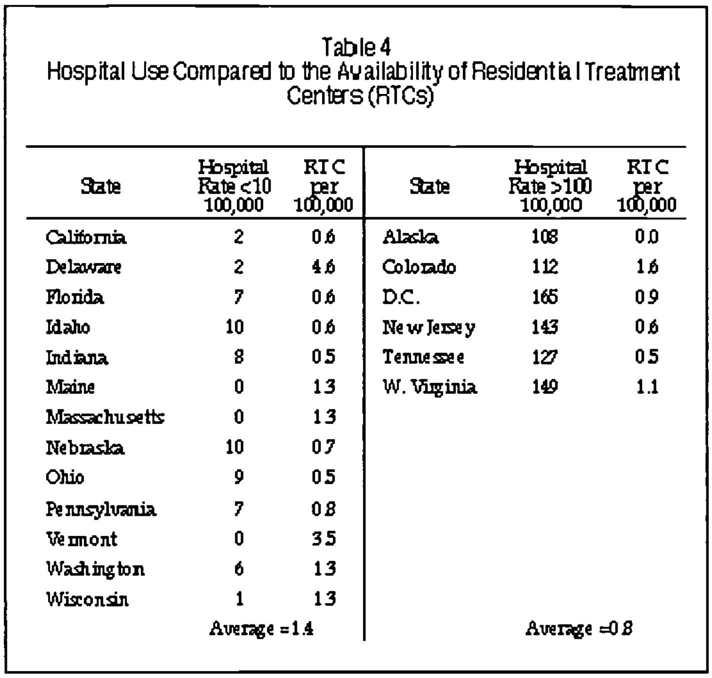

Table 4
Hospital Use Compared to the Availability of Residential Treatment Centers (RTCs)

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	

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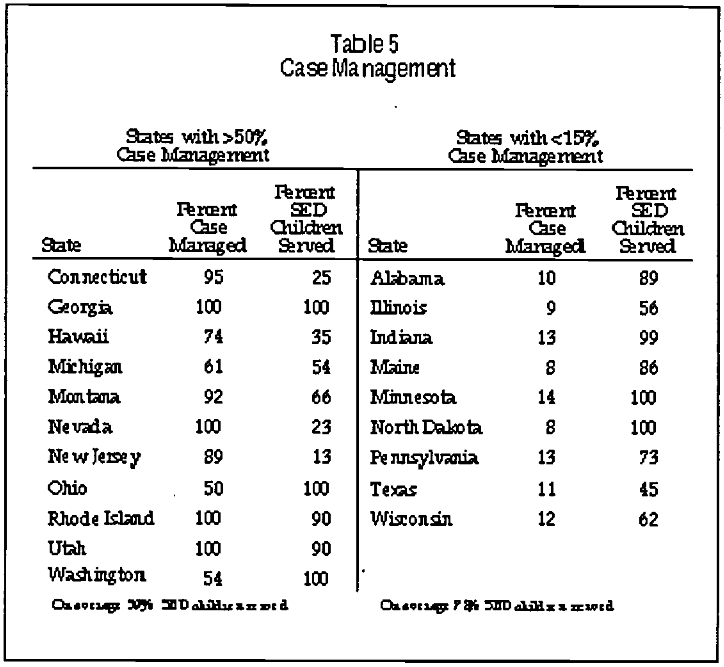

Table 5
Case Management

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 78% SED children served

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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

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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.

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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.

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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.

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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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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 uses 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 the incapacity to change the system	There is a developing sense of partnership among previously isolated groups. There is a willingness to break with tradition, when necessary. There is unison and a 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

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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 volunteers or 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 representational 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.

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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 array of information and assistance. The NGB has several regular contacts 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 representatives provide information and support for 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 government 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 government agencies.	There is an increasing amount of two-way communication between the local level, and the NGB, state and provider levels. Local government agencies offer a wide array of information and assistance. The NGB has several regular contacts at this level.	There is two-way communication between parties. The NGB and the local level communicate freely in scheduled meetings. Local government agencies offer their full array of services to the NGB. The NGB has several liaisons within local government 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 wide 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.

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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 dependent 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 variable. 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 perform the bulk of the duties on the Board. Most members perform several duties at a time.	Board growth allows for 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 more 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 for 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.

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Organization Continued

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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 by-laws 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 passively 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 providers/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 program 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.

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Resource Management Capacity

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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 NGB	A limited amount of funds is transferred from the state to the local level. The NGB 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 government bureaucracy. No attempts are made to expand the resource base beyond the Initiative.	A limited amount of discretionary funds is made available for the NGB to access directly and cover small good and service expenditures. The remainder of the funds are still under state and/or local control. The NGB 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 NGB has direct control over Initiative's funds. Bureaucratic barriers are minimal. The Board can access all goods and services directly. The NGB 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 NGB has no formal input in the managing and keeping track of funds available through the Initiative. The budget used by the NGB is the one developed for the Implementation application.	Efforts are made to track what funds are available. There is an external fiscal agent performing accounting functions for the NGB. The Board begins to amend the budget as needs arise.	There is an accounting system for the resources made available to the NGB. Goods and services are paid for as soon as possible. The NGB writes its own budget, but is still reliant on an external fiscal agent.	The budget is finalized and approved. The NGB becomes it's 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 freed by the success of the Initiative may be reallocated to the community to support programs.

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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

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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.

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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.

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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.

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

The Comprehensive Services Act: First Year Implementation Assessment

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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.

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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.

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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.

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

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

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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.

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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.

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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.

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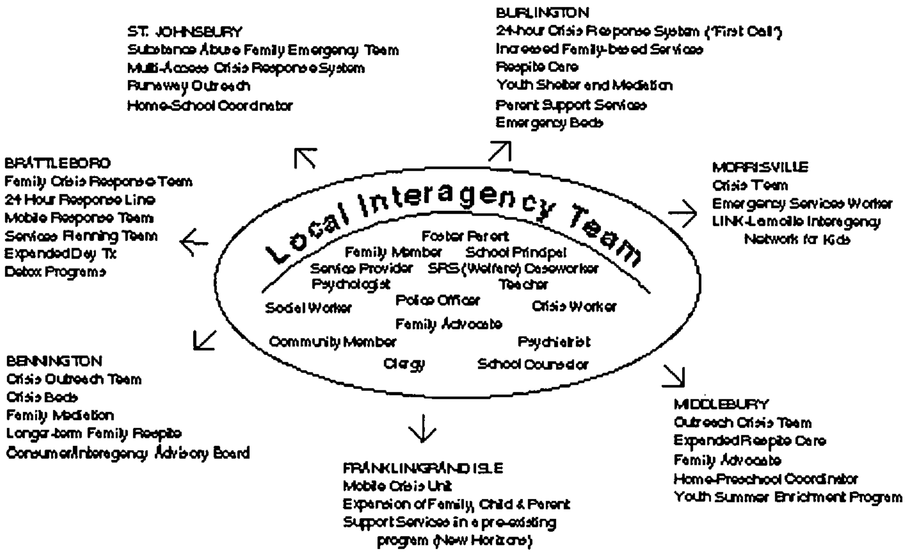
Figure 1
Designing Community-Based Services



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.

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

Conceptualization and Initial Development of the Ohio Scales

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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.

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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.

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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.

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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.

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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.

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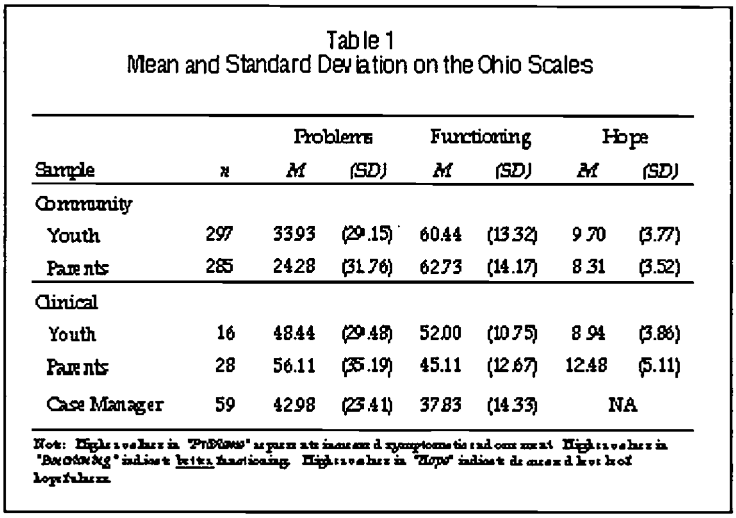

Table 1
Mean and Standard Deviation on the Ohio Scales

		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 symptomatic [illegible]. Higher values in "*Functioning*" indicate better functioning. Higher values in "*Hope*" indicate decreased level of hopefulness.

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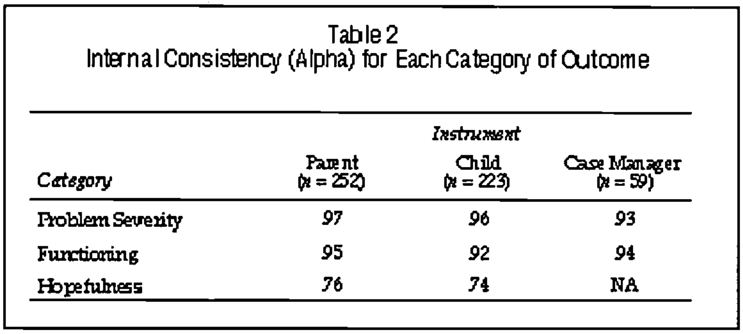

Table 2
Internal Consistency (Alpha) for Each Category of Outcome

	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

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

Impact of the Child and Adolescent Service System Program in California

Authors

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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.

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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.

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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.

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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.

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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

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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.

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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.

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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.

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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.

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

Table 1

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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, 1994.* 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. 55 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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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

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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.

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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.

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

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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.

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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.

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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.
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