

Agenda & Proceedings

The 22nd Annual Research Conference



A System of Care for
Children's Mental Health:
Expanding the Research Base

March 1-4, 2009
Tampa, Florida

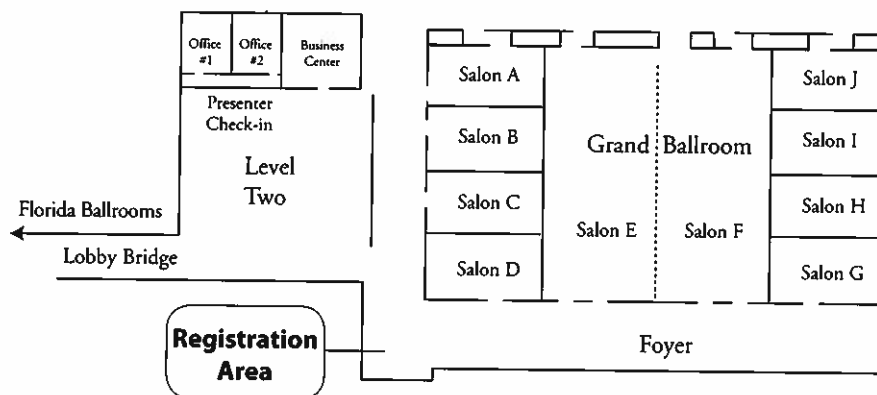
The Research and Training Center for Children's Mental Health



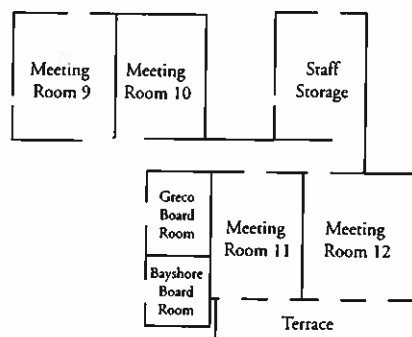
Editors:
Catherine Newman, M.A.
Cindy J. Liberton, B.A.
Krista Kutash, Ph.D.
Robert M. Friedman, Ph.D.

22nd Annual Research Conference
A System of Care for Children's Mental Health: Expanding the Research Base
Tampa Marriott Waterside

Second Floor



Third Floor



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The 22nd Annual Research Conference Proceedings
A System of Care for Children's Mental Health: Expanding the Research Base
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The Research and Training Center for Children's Mental Health
Department of Child and Family Studies
The Louis de la Parte Florida Mental Health Institute
University of South Florida
13301 Bruce B. Downs Blvd.
Tampa, FL 33612-3807
813-974-4661

<http://rtckids.fmhi.usf.edu>



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Conference Notes

Presenters, please check in!

Please see us at the Presenter Check-in Station Sunday afternoon or evening. Bring your presentation in electronic format (e.g., CD-Rom, flash-drive, etc.). We will test your files, and pre-load them in your presentation room.

Staying in Touch

Should someone need to contact you, they should call the Marriott front desk, where the call can be transferred to the 22nd Annual Research Conference. Also, check the message board located near the Information Table. During conference hours, there will be internet access so that you may check your e-mail.

Numbers to Know

Marriott Waterside Hotel & Marina
813-221-4900

Hotel Guest Fax
813-204-6342

Conference Locations

Intensive Workshops

Sun., 2:00 pm, Salons C-D

Wed., 9:00 am, Salons A-B, C-D

Poster Presentation Sessions

Sunday 6:00 pm, Salons E & F

Tuesday 5:30 pm, Salons E & F

Plenary Session,

Monday 8:30 am, Salons E & F

Tuesday 8:30 am, Salons E & F

22nd Annual

Research Luncheon,

Monday 12:00 - 1:15 pm, Salons E & F

Concurrent Sessions Monday

Meeting Rooms 9-10, 11,

Salons A-B, C, D, G, H, I, J

Concurrent Sessions Tuesday

Salon A-B, C, D, G, H, I, J

Sign-Up Meeting Rooms

Meeting Room 12

Welcome

Welcome to Tampa and to 2009! Do you feel like you are on a treadmill? Is your head spinning? It is a new year, the economy has been spiraling downward faster and deeper than we could have ever imagined, we have a new President, and significant legislation is being passed at a rapid rate. The last few minutes of the Super Bowl (held here in Tampa, of course) may be a metaphor for what is happening – rapid changes in who was winning and just when it looked like something was decided, something else happened. I am a big fan of complexity theory and it cautions about overly simplified views of how predictable the world is but this is getting ridiculous. Wow – no wonder I am tired and a little disoriented!

Hopefully during your stay here in Tampa we can provide you with a chance to catch your breath and enjoy some good weather, and with an opportunity to network with other very dedicated people who share your interests in systems of care, children's mental health, research, and evaluation. I am a little worried, though. One of the most typical reactions we get at our meeting is that the presentations are great, the exchange of ideas is stimulating and challenging, and by the end of the day, attendees are both physically and intellectually weary.

So I would urge you to be cautious—I can assure you that the quality of the presentations will be excellent again this year, and their relevance to the important work of building systems of care that effectively service children and families will be high! Be sure to pace yourself so that you can get some rest and stay physically and intellectually alert.

There are many important issues to consider this year. For example, how are we doing in bringing systems of care to scale so that they are in every community, and what do we need to do to make more progress at that? How can we move towards a more preventive, population-based public health approach while at the same time maintaining high quality services and systems for individuals with serious mental health challenges? How can we stay faithful to the values and principles that have served as such an important foundation for our work, and make sure that we translate them into our research and evaluation efforts? How can we continue to make progress in understanding how to implement systems of care effectively, how to study them appropriately, and how to genuinely create family-driven, youth-guided, culturally competent systems?

Our first plenary session will feature two young adults (Ms. Vanessa Fuentes and Ms. Brianne Masselli) offering their perspective on youth participation in research and evaluation, and a prominent senior researcher who is new to the system of care world, Dr. Abe Wandersman. Our second plenary session will feature Dr. David Hawkins, a much acclaimed researcher whose team has been involved in promoting positive change in communities around the country. From beginning to end, it should be an outstanding conference.

Our Research and Training Center is currently in the fifth and final year of its current federal grant, and the 25th year of its operation. We are hopeful to be able to continue with the Center full-scale but we are committed, whether we receive additional funding or not, to continue our annual conference. Based on the exchanges we see happening here each year, and the feedback we receive from attendees, we believe that the conference makes an important and unique contribution to the children's mental health field, and we are committed to continuing that.



Robert M. Friedman, PhD
Director, Research and Training Center
for Children's Mental Health

Krista Kutash, Al Duchnowski, and I have been here for the entire 25 years of the Center, and it has been a genuine privilege for us to have this opportunity to advance our field, and by so doing improve the lives of children and families. Cindy Liberton has been an absolutely essential part of the team for most of these years, and is now assisting us in a different capacity, having established her own communications company. I want to thank Krista, Al, and Cindy for their enormous contributions and support and I ask you, as you see them over the next few days, to offer your thanks. There are many others who have made these past 25 years an incredible experience and, as a Center, we will find time to acknowledge their contributions and thank them for their efforts.

We are not sure what the future will bring for us individually—there's that lack of predictability again—but most important we are confident that the Department of Child and Family Studies and the Louis de la Parte Florida Mental Health Institute will continue to be a valuable resource for the field and provide national leadership.

A handwritten signature in black ink that reads "Bob Friedman". The signature is written in a cursive, flowing style.

THE 22ND ANNUAL RESEARCH CONFERENCE

A System of Care for Children's Mental Health: Expanding the Research Base

OVERVIEW

Sunday, March 1, 2009	
1:00 PM	Registration Opens
2:00 - 5:00 PM	Intensive Workshop
6:00 - 7:30 PM	Poster Sessions and Networking Reception
Monday, March 2, 2009	
7:30 AM	Registration & Networking Breakfast
8:30 AM	Opening Plenary: Abraham Wandersman, Vanessa Fuentes, & Brianne Masselli
10:45 – 11:45 AM	Concurrent Sessions
12:00 – 1:15 PM	Research Luncheon
1:30 – 6:00 PM	Concurrent Sessions
Tuesday, March 3, 2009	
7:30 AM	Registration & Networking Breakfast
8:30 – 10:30 AM	Plenary Session: J. David Hawkins
10:45 – 11:45 AM	Concurrent Sessions
12:00 PM	Lunch on Your Own
1:30 – 5:15 PM	Concurrent Sessions
5:30 – 7:00 PM	Poster Sessions and Networking Reception
Wednesday, February 27, 2008	
8:00 AM	Registration and Networking Breakfast
9:00 AM – 12:00 PM	Intensive Workshops

Thank You to our Sponsors

Welcoming Reception and Poster Session Silver-level Sponsor

Shumaker, Loop & Kendrick, LLP, Tampa FL

Research Luncheon Sponsor

The de la Parte Family, Tampa FL

The late Senator Louis A. de la Parte, whose legislation in 1974 created the Florida Mental Health Institute, served the state of Florida with humility, charm and an abundance of good will in order to improve the day-to-day lives of regular people. The Institute was named for Senator de la Parte in 1996.

Acknowledgements

Our Center, which has been in operation since 1984, is based in the Department of Child and Family Studies of the Louis de la Parte Florida Mental Health Institute, University of South Florida. The success of our Center, and of our conference, is due in part to the great support of many people at our host organization, and especially our dedicated and talented team that organizes the conference every year. Join us in thanking them. Playing major roles in producing the annual conference are our Center Co-Principal Investigators, Al Duchnowski and Krista Kutash, our conference coordinator, Catherine Newman, and our event planner, Dan Casella. Others from the Department of Child and Family Studies making incredible contributions to the conference, and to the Center's work include Sandra Dwinell, Michael Greeson, Dawn Khalil, Marty Kledzik, Cindy Liberton, Storie Miller, and Jonathan Wilson, along with our Center Investigators: Mary Armstrong, Mary Evans, Paul Greenbaum, Mario Hernandez, Sharon Hodges, Kathy Lazear, Teresa Nesman, and Carol Mackinnon-Lewis. Thanks also to our very supportive and helpful Board of Advisors, Co-Chaired currently by Eric Bruns and Christina Kloker Young, and to our federal project officers, Gary Blau, Bonnie Gracer, and Diane Sondheimer.

SUNDAY, MARCH 1, 2009

Registration Opens — 1:00 pm		
<i>Presenters and volunteers, please check in!</i>	Conference Foyer	
Intensive Workshops — 2:00 PM – 5:00 PM		
Title	Presenters	Room
<i>Workshop 1 — Getting to Outcomes in Systems of Care</i>	Abraham Wandersman, Jennifer Dewey, Jody Levison-Johnson & Jason Katz	C/D
Special Session for Family Members — 5:00 – 6:00 PM Room 12		
<i>Research I: A Primer on Research Terminology and Methods for Family Members</i>	Albert Duchnowski	RM 12

Attention Family Members!
Session on Research for Families
Sunday, March 1, 2009
5:00 PM – 6:00 PM
Room 12

Interested family members are encouraged to meet and network throughout the conference. On Sunday, at 5:00 pm in Room 12, we are offering Research I, a family-friendly session where we can get to know each other as research terminology common to conference sessions is explained. At 6:00 pm, the conference's opening Poster Session begins; look for the Family Table to continue your conversations.

Your Host: Albert Duchnowski, PhD, Deputy Director, Research and Training Center for Children's Mental Health, Louis de la Parte Florida Mental Health Institute, University of South Florida

Poster Presentations & Networking — 6:00 – 7:30 PM — Salon E/F	
Title	Presenters
1. Youth and Family Perspectives: Mental Health Needs Identified: Now What?	McIntosh, Geiler, Mitchell
2. Organization of Therapeutic Practices in Treatment As Usual	Higa-McMillan, Orimoto, Mueller, Tolman
3. WATOT—An Initiative to Standardize Wraparound Services in El Paso County	Marcena, Pussman, Cobos, Temple
4. Wrapped and Reunited Using Wraparound to Support Family Reunification	Rickus, Groeber, Youmans, Grant
5. Examining the Relationships between Family-Run Organizations and Systems of Care	Lazear, Anderson
6. Factors Affecting Long-Term Outcomes Following Intensive In-Home Services	Hurley
7. Positive Psychology: Enhancing Strength-based Practice	Groves
8. Implementing Evidence Based Interventions in Community Mental Health: An Outcome Study	Starin, Wehrmann
9. Adoption and Implementation of Trauma-focused Cognitive Behavioral Therapy, an Evidence-based Practice	Montagno
10. Enhancing and Adapting Evidence-Based Principles for "Real World" Practice	Murray, Kelsey, Farmer, Burns
11. Relationships Between Child and Family Strengths and Child Outcomes	Radigan, Wang
12. Intensive Community Based Service Grant: Preliminary Outcomes	Chandra
13. Identification of Strengths in Children: Use of Evaluation Data to Improve Services	Taylor
14. Redesigning a Neighborhood System of Care in the South Bronx	Fear, Pessin, Lindy
15. Communicating System of Care Results	Effland, Kasinger, Bajwa
16. Using the SOCPR as an Ongoing Tool for Program Improvement	Vergon, Mayo, Picora

Title	Presenters
17. The Price of Collaboration: Predictors of Hours Spent in Collateral Contacts	Gordon
18. Review of Preschool Antipsychotic Prescribing Prior Authorization Form Formatting and Layout; Considerations for Modification, A Quality Improvement Project	Bengtson
19. The Impact of a Learning Collaborative upon Child Mental Health Service Use	Cavaleri, Gopalan
20. Using Data to Inform Decision-Making in Kansas Children's Community-Based Services	Kapp, Stipp
21. Support Services and Child Outcomes among Children Served in a Systems-of-Care Program	Azur, Godoy Garazza
22. Culturally Competent SOC in the 21st Century	Blackmon, Purce
23. ¡ADELANTE! Advancing a Network's Cultural Proficiency	Albo, Miller, Hopkins
24. Using Data Analysis to Improve System of Care Services for American Indians	Dickerson, Johnson
25. Assessing Consumer-Driven and Culturally-Competent Care	Saarnio, Cash
26. Developing a Culturally Responsive Assessment Tool for Native American Youth	Jivanjee, Friesen, Fox, Matthew
27. Creciendo Unidos/Creating Alternatives: An Overview of a Cross Generational Community Driven Practice	Vaca
28. Creating Trauma Informed Care Environments: A Learning Collaborative for Youth Residential Treatment	Hummer, Dollard, Myers-Routt
29. Addressing the Mental Health Needs of Children Who Have Witnessed Domestic Violence	Amrani-Cohen
30. Needs and Services of Sexually Abused Children	Brown, Labouliere
31. Antipsychotic Medication Utilization Among Children Prior to Out-of-Home Care	Robst
32. The National Workgroup to Address the Needs of Youth Who Are LGBTQI2-S and their Families in Systems of Care	Fisher, Poirier

MONDAY- MARCH 2, 2009

Monday General Session – 8:30 – 10:30 AM

Plenary Session: System of Care Values in Research and Evaluation	Abraham Wandersman, Vanessa A. Fuentes, Brienne Masselli	E/F
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Monday Morning Concurrent Sessions — 10:45 – 11:45 AM

Session	Title	Presenters	RM
1	symposium: A Research Agenda for Protecting Children and Youth in Residential Programs	Friedman	A/B
	element of symposium: Key Research Questions	Behar	
	element of symposium: Potential Abuses and Effects on Families	Kloker-Young	
	element of symposium: Impact on Youth: Existing Research	Lombrowski	
2	symposium: Structure and Role of Information Management in Systems of Care	Effland, Rotto	C
	element of symposium: Components of an Information Management System	Effland, Van Deman	
	element of symposium: Identifying Core Information Needs	Klein	
	element of symposium: Quality Improvement and Decision Making	Van Deman, Tekle	
3	symposium: What Works, What We Think Works, and How It Can Work for You	Kutash, Epstein	D
	element of symposium: Can You Handle the Truth? Understanding What Works Clearinghouse Standards of Evidence	Sumi	
	element of symposium: Does Practice Make Perfect? What the IES Behavior Practice Guide on Reducing Behavior Problems Can Offer You	Woodbridge, Epstein	
4	paper presentation: Measuring Family Outcomes in Family to Family Support: Development of a Family Needs and Strengths Assessment (FANS)	Craig, McCarthy, Radigan	G
	paper presentation: Using a Community of Practice to Define the Role of Family Partners in Wraparound	Penn, Osher, Sather	
5	symposium: Advances in Services for Transition Age Youth	Davis, Heflinger	H
	element of symposium: Identifying and Helping Transition Age Youth at Risk of Arrest	Davis, Sheidow	
	element of symposium: Better Linkages Between Child and Adult Services: A Social Network Analysis	Koroloff, Davis	
6	paper presentation: Gender Differences in Patterns of Child Risk Across Programmatic Phases of the CMHI	Azur, Godoy Garazza	I
	paper presentation: Lessons Learned from the National Evaluation of the Comprehensive Community Mental Health Services for Children and their Families Program: Community Voices of Experience	Maples, Whalen	
7	symposium: Bring It Home: Using the National Longitudinal Outcomes Study for Local Evaluation	Wojack, Powers	J
	element of symposium: Local Continuous Quality Improvement Process and Findings	Wojack, Powers	
	element of symposium: Methodology for Retrieving and Presenting Local Data from the National Evaluation	Wiles	
	element of symposium: National Evaluation Support to Help Communities Maximize Use of the Data	Moore	

Research Luncheon — 12:00 – 1:15 PM – Florida Ballroom
sponsored by the de la Parte Family

Monday Afternoon Concurrent Sessions — 1:30 – 3:00 PM

Session	Title	Presenters	RM
8	symposium: Parent Support: Emerging Empirical Evidence – Part 1	Kutash, Burns	A/B
	element of symposium: Psychoeducational Psychotherapy: A Collaborative Family-Clinician Model of Care	Fristad	
	element of symposium: An Empirical Investigation of a Parent Support Program: Parent Connectors	Duchnowski, Kutash	
9	symposium: Framing Systems Change: Relating the Parts to the Whole	Hodges, S.	C
	element of symposium: Introductory Comments	Hernandez	
	element of symposium: The Value of Systems Thinking in Complex Community Change	Foster-Fishman	
	element of symposium: The Interactive Systems Framework for Dissemination & Implementation	Wandersman, Manteuffel	
	element of symposium: Factors in SOC development	Hodges, S.	
10	symposium: Implementing Mental Health Care Interventions with Vulnerable Youth in their Natural Surroundings	Bannon, Jr.	D
	element of symposium: The Association Between Youth Group Participation and Reduced Youth Behavioral Difficulties	Bannon, Jr.	
	element of symposium: STEP-UP: A Youth-Centered, Family-Linked, Community and School-Based Alternative Mental Health Intervention Program for At-Risk Inner City Youth	Alicea	
	element of symposium: Preliminary Qualitative Findings Reflecting Staff Successes and Challenges in Implementing the Clinic Plus Program	Cavaleri	
11	symposium: Early Childhood Systems of Care: Perspectives from Three Federally Funded Sites	Whitson, Fisher	G
	element of symposium: Characteristics of Children Presenting to Early Childhood Mental Health SOC	Crusto	
	element of symposium: Six-month Outcomes for Children Receiving Services within an Early Childhood System of Care	Kaufman, Whitson	
	element of symposium: Translating Research into Practice: Strategies for Implementing a Public Health Approach to Early Childhood Mental Health	Berson	
12	symposium: Transition to Adulthood: Services and Natural Supports Associated with Success	Clark, Koroloff	H
	element of symposium: Young Adults' Perspectives on Social Support during Transition to Postsecondary Work/Education	Taylor	
	element of symposium: Transition to Adulthood Roles: Young Adults Perspectives on Factors Contributing to Success	Deschènes	
	element of symposium: Improving Transition Outcomes: Evaluation of Needs, Service Utilization and Progress/Outcome Indicators	Dresser, Zucker	
13	symposium: Successful Juvenile Justice Diversion: Impact on the Youth's Functioning, Recidivism, and System Costs	Hodges, K.	I
	element of symposium: Diversion and Family Based Services Reduce Cost and Entry into Adjudicated Juvenile Justice	Smith, Heimbuch	
	element of symposium: Pre to Post Outcomes for Youth Served by a Juvenile Justice Diversion Program	Hodges, K.	
	element of symposium: Youth Assistance Program Prevents Progression Through the Juvenile Justice System	Williams	
	element of symposium: Beacon of Light: A Parent's Perspective on the Impact of Diversion	Sheppard, Depriest	

MONDAY – MARCH 2, 2009

14	symposium: Beyond Didactics: Emerging Evidence on EBP Implementation Strategies in New York State	Hoagwood	J
	element of symposium: Initial Findings and Implications of the Evidence-Based Training Dissemination Center (EBTDC)	Gleacher	
	element of symposium: Disseminating EBTs for Children: A Microanalysis of Consultation Calls as an Ongoing Training Strategy	Pimentel	
	element of symposium: A Family Support Service Model for Implementing Evidence-Based CBT	Rodriguez	
	element of symposium: Transporting Evidence-Based Practice to School Settings: Examining Strategies for Consultation	Mass-Levitt	
Monday Afternoon Concurrent Sessions — 3:15 – 4:45 PM			
Session	Title	Presenters	RM
15	symposium: Parent Support: Emerging Empirical Evidence – Part 2	Kutash, Penn, Burns	A/B
	element of symposium: Parents as Change Agents: The Parent Empowerment Program for Parent Advisors	Hoagwood, Burton	
	element of symposium: Development, Implementation and Evaluation of the NAMI Basics Education Program	Brister	
16	symposium: The Perfect Storm – The Convergence of Data, Process and Dialogue for System of Care Development	Levison-Johnson, Hernandez	C
	element of symposium: Waves of Change: Targeting and Measuring Systems Reform in Oklahoma	Pirtle	
	element of symposium: Waves of Change: Examining System-Wide Indicators of Performance in Monroe County	Levison-Johnson, Plum	
	element of symposium: Waves of Change: Using the CMHI Benchmarking Initiative and Progress Report as a Model for System Improvement	Bledsoe	
17	paper presentation: Knowledge of and Attitudes Toward Services among Youth Transitioning from Foster Care	Munson, Narendorf, McMillen	D
	symposium: Together Facing the Challenge: Preliminary Findings from a Randomized Clinical Trial of Therapeutic Foster Care	Southerland, Murray, Farmer	
	element of symposium: Together Facing the Challenge – Implementation and Preliminary Findings of a Randomized Clinical Trial of Therapeutic Foster Care	Farmer, Murray	
	element of symposium: Measuring Fidelity of Implementation of an Enhanced Model of Therapeutic Foster Care	Southerland, Farmer	
18	paper presentation: Development of a Strength-Based Scale for Use with Preschoolers	Epstein	G
	paper presentation: Head Start, Mental Health and Integrated Continuous Improvement Processes	Smith, Broyles, Ehlling	
	paper presentation: A Complexity Approach to Systems of Care for Early Childhood Mental Health	Pinto	
19	paper presentation: Understanding the Associations of Child Welfare and Juvenile Justice Involvement of Adults with Severe Mental Illness and Criminal Justice Contacts	Haynes, Becker, Andel, Robst	H
	paper presentation: Bridging the Gap Between Community Mental Health and Juvenile Justice Systems	Kapp, Robbins, Choi	
	paper presentation: Evaluating Project Connect: Training on Mental Health Linkage for Juvenile Probation Officers	Wasserman, McReynolds	
20	paper presentation: Emergency Commitment of Young Children	Christy, Haldeman	I
	paper presentation: Length of Pediatric Mental Health Emergency Department Visits in the United States	Case	
	paper presentation: Out-of-Home Placement Following a Psychiatric Crisis Episode Among Children and Youth	Park	

21	symposium: Spreading and Sustaining Best Practices through the Learning Collaborative Model	Seagle, Huang	J
	element of symposium: The NCCTS Learning Collaborative Model for the Adoption and Implementation of Mental Health Evidence-Based Practice	Markiewicz, Amaya-Jackson	
	element of symposium: “What Are We Going to Need to Implement This?” Disseminating the Learning Collaborative Methodology in Four States	Seagle	
	element of symposium: Applying the Learning Collaborative Methodology to System of Care Practice—Alamance Alliance	Markiewicz	
Monday Afternoon Concurrent Sessions — 5:00 – 6:00 PM			
Session	Title	Presenters	RM
22	symposium: Community Mobilization toward Evidence Based Practice: Implementation and Testing of Two Strategies in Washington State	Bruns, Friedman	A/B
	element of symposium: Partnerships for Success in Washington State: A Community-Based Model to Effectively Implement Evidence-Based Practices for Youth	Kerns, Bruns, Trupin, Enns	
	element of symposium: Project Focus: Effective Mental Health Practices for Washington's Foster Children	Dorsey, Kerns, Etchison, Trupin	
23	topical discussion: From Principles to Practice: System of Care Program Installation and Governance	Bertram, Bane, Williams, Johansson	C
24	topical discussion: Methodological Considerations in Evaluating Preschool Risk, Resilience, and Trauma: In and Out of Child Welfare.	Stein, Stettler, Chinitz, Pecora	D
25	paper presentation: The Impact of Family Education and Support Services in System of Care Communities	Gyamfi	G
	paper presentation: Reducing Stress and Employment loss for Parents of Children with Mental Health Disorders	Brennan	
26	Topical discussion: Critical Success Factors to Achieve Family-Driven, Youth-Guided System Planning	Alfreds, Hardesty, Kennedy, Ferrone	H
27	paper presentation: The National Behavior Research and Coordination Center: Overview and Final Findings	Sumi, Woodbridge, Wagner	I
28	symposium: 2008 Honoring Excellence in Evaluation (HEE) Event: Recipients Share their Work	Fisher, Whalen	J

MONDAY SPECIAL SESSIONS

Special Session A

Cultural Competency:

What is “Mental Health” in Indigenous, Island, and Immigrant Populations? 1:30 - 2:30 PM

This discussion will explore the meaning of mental health for indigenous, island, and immigrant populations, and the cultural dimensions that impact access, utilization, and satisfaction with mental health services in systems of care. National evaluation staff will provide context and conduct a mapping process for participants to identify these populations within their cities, counties, and states. System of care community representatives will present their experience and related data on this topic.

Panel: Jennifer Dewey; Freda Brashears; Ranilo Laygo; Bonnie Brandt

RM 11

Special Session B

A New Report from the National Research Council and Institute of Medicine: Preventing Mental, Emotional and Behavioral Disorders Among Young People: Progress and Possibilities

Monday, 3:15 to 4:45, Meeting Room 8-10

On February 13, 2009, the National Research Council and Institute of Medicine released a new report, Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. The report summarizes the progress made in prevention research over the last 15 years and prioritizes the research agenda for the future. It examines definitions of prevention, the developmental, epidemiologic, and ecological bases for developing and testing preventive interventions and reviews the progress made from rigorous experiments across the life span and contexts. It also outlines advances in genetics and neuroscience, and implementation science, that offer new opportunities for conducting prevention research and moving these prevention programs that benefit our children much more broadly into community, social service, and institutional settings. The panel will present this newly released report, with a focus on recommendations relevant to research and policy.

Panel: C. Hendricks Brown, Peter Pecora & Mary Ellen O’Connell.

RM 9

TUESDAY–MARCH 3, 2009

Tuesday Morning Plenary Session I — 8:30 – 10:30 AM			
PL	Gwen Iding Brogden Distinguished Lecture Series Planning for Prevention	J. David Hawkins	E/F
Tuesday Morning Concurrent Sessions — 10:45 – 11:45 PM			
Session	Title	Presenters	RM
Spec	<i>conversation hour with J. David Hawkins</i>		9
29	<i>paper presentation:</i> Substance Use, Youth and Family Characteristics: Effects on Service Recommendations and Delivery	Whitson, Kaufman	A/B
	<i>paper presentation:</i> Differences in Patterns of Substance Use in Caucasian and African American Adolescents	Daniels	
30	<i>symposium:</i> Systems of Care Practice Review's Impact Home and Abroad (Iowa and Ottawa)	Armstrong, Alfreds	C
	<i>element of symposium:</i> Iowa's Children's Mental Health System Evaluation Utilizing the SOCPR	Roggenbaum, Hummer, Alger	
	<i>element of symposium:</i> Using the SOCPR to Facilitate System Transformation Efforts in Ottawa, Canada	Talartcheff-Quesnel, Gravelle, Hone	
31	<i>paper presentation:</i> Communication and Interaction of Pediatricians with Systems of Care	Riehman	D
	<i>paper presentation:</i> Improvement for Youth with Disruptive Behaviors Provided Evidence-Based Practices	Mueller, Tolman, Ebesutani, Bernstein	
32	<i>paper presentation:</i> Trends, Challenges & Opportunities in Conducting Culturally-Sensitive Evaluations of Child Mental Health Programs	Nichols Johnson, Mitchell, Valenzuela	G
	<i>paper presentation:</i> Financing and Sustainability in American Indian and Alaska Native (Tribal) Systems of Care	Echo-Hawk, Krivelyova, Lichtenstein	
33	<i>paper presentation:</i> System of Care and Usual Services in the U.S.: Comparing Service Outcomes	Pottick, Perry	H
	<i>paper presentation:</i> Multilevel Framework for Integrating the Formative and Summative Functions of Evaluation in Mental Health	Brannan	
34	<i>paper presentation:</i> Social Connectedness of Families in Wraparound: Implications for Practice	Cook, Kilmer	I
	<i>paper presentation:</i> Selecting Residential or Community Based Care - Parent Survey Results	Starin	
35	<i>symposium:</i> The Statewide Implementation of Evidence-Based Practice: Outcomes and Lessons Learned from the Evaluation of MST in Connecticut	Schroeder	J
	<i>element of symposium:</i> Is MST Effective for Connecticut's Highest Risk Children and Youth? Quantitative Outcomes from a Statewide Evaluation of MST	Schroeder, Connell	
	<i>element of symposium:</i> How is MST Working in Connecticut? Qualitative Outcomes from a Statewide Evaluation of MST	Schroeder	
	<i>element of symposium:</i> What are the Lessons Learned from the Statewide Dissemination of an Evidence-Based Practice? MST, Knowledge Transfer, and Policy in Connecticut	Franks	

Tuesday Afternoon Concurrent Sessions — 1:30 – 3:00 PM			
Session	Title	Presenters	RM
36	<i>symposium:</i> Financing Strategies that Support Effective Systems of Care	Armstrong, Hudock	A/B
	<i>element of symposium:</i> Implementing and Financing Evidence Based Practices in Systems of Care	Pires, Wotring	
	<i>element of symposium:</i> Re-Directing "Deep End" Spending through Care Management Entities	Pires, Armstrong	
	<i>element of symposium:</i> Financing Early Childhood Systems of Care	Stroul, Wood	
37	<i>paper presentation:</i> Identifying What Makes Systems of Care Successful	Effland, McIntyre	C
	<i>paper presentation:</i> The Family Networks Initiative: A Collaboration	Alvarez de Toledo	
	<i>paper presentation:</i> Collaborating with Community-Based Organizations in Developing Systems of Care	Nesman, Callejas, Mowery	
38	<i>symposium:</i> System of Care Implementation: Findings from a National Survey	Kutash, Friedman	D
	<i>element of symposium:</i> System of Care Implementation	Friedman	
	<i>element of symposium:</i> Development of the System of Care Implementation Survey and County Selection and Respondent Identification and Recruitment Procedures	Boothroyd	
	<i>element of symposium:</i> Overview of the System of Care Implementation Survey (SOCIS) Instrument and Descriptive Results from 225 Counties	Kutash	
	<i>element of symposium:</i> Multilevel Confirmatory Factor Analysis of the SOCIS	Greenbaum	
39	<i>paper presentation:</i> Risk and Protective Factors in Native American Youth: A Preliminary Analysis	Friesen, Gowen, Fox, Matthew	G
	<i>paper presentation:</i> Tribal Youth Victimization and Delinquency: Analysis of Youth Risk Behavior Surveillance Data	Pavkov, Travis, Fox, Harding	
40	<i>paper presentation:</i> Diffusion of Trauma-Informed Policies and Practices among Mental Health Agencies	Rivard, Walrath, Gilford Jr., Hovor	H
	<i>paper presentation:</i> Evaluation of an Intervention for Adolescent Girls with Trauma Related Disorders	Elzy	
	<i>paper presentation:</i> An Evaluation of Boys Town's Family Preservation Program	Griffith, Hurley, Ingram, Cannezzaro	
41	<i>paper presentation:</i> Building a Research Agenda: Implementation Research and Wraparound Literature	Bertram	I
	<i>paper presentation:</i> Evaluation of Wraparound Services within Erie County	Pagkos, Milch, Kazi	
	<i>paper presentation:</i> A Rural, Non-Profit Model for Workforce Wraparound Readiness in Systems of Care	Lourie, Folsom, Gallagher	
42	<i>paper presentation:</i> System of Care Community Plans for, and Caregiver Perceptions of, Evidence-Based Treatments	Moore, Lichtenstein	J
	<i>paper presentation:</i> Factors Associated with Perceptions of Need for Child and Adolescent Psychiatrists	Lewandowski, Kaye	
	<i>paper presentation:</i> Understanding Community-based Administrators' and Clinicians' Perspectives on Evidence-Based Treatment Implementation	Herschell	

TUESDAY- MARCH 3, 2009

Tuesday Afternoon Concurrent Sessions — 3:15 – 4:15 PM			
Session	Title	Presenters	RM
43	symposium: Conflict and Its Management in Systems of Care	Evans	A/B
	element of symposium: Results of a National Survey of Federally Funded Systems of Care	Evans, Chen, Boothroyd	
	element of symposium: Use of Concept Mapping to Understand Conflict Management in Systems of Care	Chen, Boustead	
	element of symposium: Talking About Conflict	Schrepf	
44	symposium: Improving Client Outcomes through Effective Implementation of EBP's: Provider Organizations' Perspectives	Brown, Wotring	C
	element of symposium: Harmony in Duality: Using Evidence-Based Programs to Transform the Traditional Parts of Your Agency	Hayes, Emilio	
	element of symposium: The Implementation of Evidence-Based Practice in a Children's System of Care: What Worked and What Didn't	Dunst	
	element of symposium: A Demonstration of Improving Client Outcomes as a Result of Effective Implementation Processes and Appropriate Evidence-Based Practices	Brown, Sheridan	
	element of symposium: Implementation of Evidence-Based Practices: An Evaluation of a Monumental Organizational Change Process	Barwick, Ferguson	
45	paper presentation: Psychotropic Medication Utilization in Two Intensive Residential Programs	Thompson, Griffith	D
	paper presentation: ROLES Revision Project: General Environment Types	Thompson, Pecora	
46	paper presentation: Community Defined Evidence: Research from the Ground Up	Callejas, Martinez	G
	paper presentation: Utilizing Family Workers in the Delivery of Mental Health Services	Yengo	
47	paper presentation: First Look: The Intergenerational Effects of Trauma on Child and Family Outcomes	Goan, Hornby	H
	paper presentation: Addressing Suicide Issues in Systems of Care Communities: How are Caregiver Strain and Youth Suicide Attempt Related? And How Can We Help Children and Families?	Barksdale, Fisher	
48	paper presentation: WFI for CQI—Measuring Change in Wraparound Fidelity after Implementing Improvement Efforts	Kernan, Pagkos	I
	paper presentation: Effects of Wraparound from a Meta-Analysis of Controlled Studies	Suter, Bruns	
49	topical discussion: Promoting Effective Behavioral Health Practices in a Statewide System of Care	Franks, Vanderploeg, Schroeder, Lang, Matlin, Bracey	J

Tuesday Afternoon Concurrent Sessions — 4:15 – 5:15 PM			
Session	Title	Presenters	RM
50	topical discussion: Discussion Hour—From Good to Great and Beyond: Recent Research on Effective Organizations	Friedman	A/B
51	symposium: The Building Bridges Initiative: A Framework for Self-Assessment to Improve Organizational Practices	Lieberman	C
	element of symposium: An Overview of the Building Bridges Initiative and the Framework for Self-Assessment	Lieberman	
	element of symposium: Design and Structure of the Matrix and the S.A.T.	Lieberman	
	element of symposium: Field Testing the Self-Assessment Tool and Next Steps	Dougherty	
52	topical discussion: Asset-Based Research and a Public Health Approach to Addressing the Needs of Lesbian, Gay, Bisexual, Transgender, Questioning, Intersexed, and Two-Spirit (LGBTQI2-S) Youth and Families	Lazear, Gamache, Fisher	D
53	paper presentation: Developing Culturally Competent Systems of Care	Lichtenstein	G
	paper presentation: Using Social Network Analysis to Study Inter-Agency Collaboration in Children's Mental Health Service Systems	Sukumar	
54	topical discussion: Strong Communities: Community-Wide Strategies to Keep Kids Safe	Motes, Kimbrough-Melton, Melton	H
55	topical discussion: Using Finance to Improve Access and Quality of Treatment for Adolescents with Substance Use and Co-Occurring Disorders	Cavanaugh, Nance, Janes, Fretwell	I
56	topical discussion: The Use of Data to Assist the Implementation of Evidence Based and Promising Practices: Systemic, Organizational and Individual Perspectives	Wotring, Bernstein, Carter, Collins	J

TUESDAY SPECIAL SESSIONS

Special Session C: Topical Discussion—Rapid Ethnography as Community-Based Participatory Research: Real Research for Real World Settings 1:30 - 3:00 PM

Community-based participatory research is described as a collaboration between researchers and participants, in which community stakeholders are engaged as members of the research team. The utilization of this type of research model within the field of mental health has broadened over the last few years, particularly in relation to community change efforts. Rapid ethnographic methods are often used by a research team to collect a large amount of data within a short period of time. This topical discussion will describe the integration of community-based participatory research and rapid ethnographic methods in the study of system-of-care communities. Leaders from two communities that participated in Case Studies of System Implementation will describe their experiences during the research project, including the challenges and benefits of this type of research and how they have utilized study results. The topical discussion will allow audience members to engage in discussion around this process.

Panel: Sharon Hodges; Kathleen Ferreira; Myra Alfreds; Knute Rotto

RM 9

Special Session D: Discussion—Best Practices for Mental Health in Child Welfare 3:15 - 2:30 PM

The 2007 Best Practices for Mental Health in Child Welfare Consensus Conference brought together experts in the fields of child welfare and mental health research, policy and services as well as parent and youth child welfare advocates to discuss the best ways to address the mental health needs of youth in the child welfare system. As a result of the conference, 32 guidelines covering the areas of mental health screening and assessment, psychosocial interventions, psychopharmacological interventions, parent support, and youth empowerment were developed. This discussion will provide a brief overview of the guidelines, their development, and rationale and discuss the implications of the guidelines from the perspective of child welfare agencies and families.

Panel: Lisa Romanelli; Peter Pecora; Robert Hartman; Corvette Smith

RM 9

TUESDAY MARCH 3, 2009

Poster Presentations & Networking — 5:30 – 7:30 PM — Salon E/F	
Title	Presenters
1. The Effects of the Rater on Racial Differences in Child Behavior Problems	Azur
2. Ohio Problem Scale: Implications of CFA Model Misfit for Scale Utility	Baize, Jackson
3. Ensuring an Equitable Representation of African Americans in Evaluation	Lewis, Sullins
4. Learning Collaborative Metrics as Performance and Fidelity Measurements	Vergon, Blacklaw, Stone, Born
5. Using WFI-4 Principle and Phase Scores to Assess Wraparound Facilitator Burnout	Welsh
6. Community Indicators and Systems of Care Implementation	Lunn
7. Real World/Real Time Performance Measurement: Supervision Strategies to Enhance SOC Outcomes	Grimes, Lehar
8. Family Driven Flexible Funds: Using Technology to Improve Systems	Robbins, Scott, Maziarz
9. Perspectives of Treatment Foster Parents on Transitioning Youth to Family Settings	Castellanos-Brown, Lee
10. Special Needs Adoptive Children: A Compelling Case for Long Term Cross-System Collaboration	Hussey
11. Engagement of Non Resident Fathers in Child Welfare	Edwards, Fluke
12. Non-Kin Natural Mentoring Relationships Among Transitioning Foster Care Youth	Munson, Smalling
13. Juvenile Justice System Involvement and Recidivism among Youths Placed in Out-of-Home Care	Yampolskaya, Armstrong
14. Evaluation of Youth Functional Outcomes in Maryland's Group Homes	Stephan, Mettrick, Chow, Keegan
15. Perspectives on Residential and Community-Based Treatment for Youth and Families	Kamins, Hopkins, Hunt
16. Predictors of Out-of-Home Placement by Race/Ethnicity	Garcia, Marcenko
17. School/Employment Status of Youth Accessing Residential Treatment or Intensive Family Services	Frensch
18. The Lived Experience of Primary Caregivers of Children with Mental Health Needs	Gerkenmeyer, Oruche, Stephan, Al-Khattab
19. Connecticut's Family-Based Recovery Program: Quality Assurance and Evaluation Results of a Statewide, Multi-Site Intervention for Children Affected by Parental Substance Abuse	Vanderploeg, Connell
20. Factors Effecting Family Participation in Mental Health Services for Children with SED	Satterwhite
21. Framework for Empowering Parents as Change Agents: From Science to Action	Hoagwood, Rodriguez, Burton, Penn
22. Simulating Waiting List Reduction Strategies in Children's Mental Health: A Discrete Choice Conjoint Analysis of Parental Preferences	Cunningham
23. The Iterative Process of Implementing and Evaluating a School-Based Depression Prevention Program	Cunningham
24. Families First: Innovative Approaches to Increasing Family Involvement in Treatment	Winans, Pearson, Hodges, K.
25. Supporting Positive Transitions to Kindergarten: Parent Perspectives on Early Childhood Education Systems	Malsch
26. Routine Screening to Identify Mental Health Problems in Pediatric Primary Care	Brown
27. Hillsborough County's Civil Citation Project: Assessing Local Response to School-Related Justice Involvement	Sullivan, Dollard, Mayo,
28. Consumer-Driven Evaluation and Youth Voice: The Inside-Outside Partnership for Massachusetts' Transition Age Youth Initiative Program and Policy	Mikula, Frankford
29. Emotional and Academic Outcomes for Students in a School-Based Partial Hospitalization Program	Prator
30. Critical Components for Developing and Sustaining A School-Based Family Peer Support Program	Davis, Grubbs, Barkley, Crosby

WEDNESDAY MARCH 4, 2009

Intensive Workshops — 9:00 AM – 12:00 PM		
Title	Presenters	Room
<i>Workshop 2— Concept Mapping as a Next Generation, Multi-Use Strategy</i>	Behar, Hydaker, Paulson	A/B
<i>Workshop 3— Building the Research Base: Grant Funding Opportunities at the Institute of Education Sciences (a.k.a. "Show Me the Money")</i>	Buckley	C/D

Sunday Intensive Workshop, March 1 » 2:00 pm

Intensive 1—Salon C/D

Getting to Outcomes in Systems of Care

Abraham Wandersman, Professor, Psychology, University of South Carolina-Columbia, Jennifer Dewey, Macro International, Jody Levison-Johnson, Monroe County ACCESS and Coordinated Care Services, Inc., and Jason Katz, University of South Carolina

How can we increase the probability of being successful in systems of care? This session will explore how the Getting to Outcomes (GTO) system can be applied to planning, implementing and evaluating systems of care with particular emphasis on performance measurement and quality improvement. Getting to Outcomes provides an empowerment evaluation system that has showed promise for addressing complex social issues such as teen pregnancy, child maltreatment, youth violence and substance abuse. The GTO system uses 10 accountability questions; addressing the 10 questions involves a comprehensive approach to results-based accountability that includes evaluation and much more. It includes: needs and resource assessment, identifying goals, population of focus, desired outcomes (objectives), science and best practices, logic models, fit with existing programs and initiatives, planning, implementation with fidelity, process evaluation, outcome evaluation, continuous quality improvement, and sustainability.

Partners from the national evaluation team and a local system of care community will share experiences and highlight the applicability and benefits of the GTO framework for system of care communities.

Sunday Poster Session, March 1 » 6:00 pm » Salon E-F

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3	Wraparound Training of Trainers (WATOT): An Initiative to Standardize Wraparound Services in El Paso County <i>Luther Marcena, Vashti Pussman, Anthony Cobos & Wes Temple</i>	13
4	Wrapped and Reunited Using Wraparound to Support Family Reunification <i>Irene Rickus, Chris Groeber, Eileen Youmans & Virginia Grant</i>	14
5	Examining the Relationships between Family-Run Organizations and Systems of Care <i>Katherine Lazear & Rene Anderson</i>	15
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9	Adoption and Implementation of Trauma-Focused Cognitive Behavioral Therapy, an Evidence-Based Practice, and Related Resources, in the National Child Traumatic Stress Network <i>Angela Montanago</i>	19
10	Together Facing the Challenge: Enhancing and Adapting Evidence Based Principles for "Real World" Practice—A Therapeutic Foster Care Toolkit <i>Maureen Murray, Kelly Kelsey, Elizabeth Farmer & Barbara J. Burns</i>	20
11	Relationships Between Child and Family Strengths and Child Outcomes <i>Marleen Radigan & Rui Wang</i>	21
12	Intensive Community Based Service Grant: Preliminary Outcomes <i>Shweta Chandra</i>	22

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16	Using the System of Care Practice Review (SOCPR) as an Ongoing Tool for Program Improvement <i>Keren Vergon, John Mayo & Beth Picora</i>	27
17	The Price of Collaboration: Predictors of Hours Spent in Collateral Contacts <i>Michael Gordon</i>	28
18	Review of Preschool Antipsychotic Prescribing Prior Authorization Form Formatting and Layout; Considerations for Modification, A Quality Improvement Project <i>Michael Bengtson</i>	29
19	The Impact of a Learning Collaborative upon Child Mental Health Service Use <i>Mary Cavaleri & Geetha Gopalan</i>	30
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21	Support Services and Child Outcomes among Children Served in a Systems-of-Care Program <i>Melissa Azur & Lucas Godoy Garazza</i>	32
22	Culturally Competent Systems of Care in the 21st Century: Challenges of the 20th and 21st Century <i>Betty Blackmon & Deborah Purce</i>	33
23	¡ADELANTE! Advancing a Network's Cultural Proficiency...aka "It doesn't take a Rocket Scientist to Build a Culturally Competent System of Care" <i>Malena Albo, Matt M. Miller & Bonni D. Hopkins</i>	33
24	Using Data Analysis to Improve System of Care Services for American Indians <i>Daniel Dickerson & Carrie Johnson</i>	34
25	Assessing Consumer-Driven and Culturally-Competent Care <i>David Saarnio & Valencia Cash</i>	35
26	Developing a Culturally Responsive Assessment Tool for Native American Youth <i>Pauline Jivanjee, Barbara Friesen, Kathleen Fox & Cori Mathew</i>	36
27	Creciendo Unidos/Creating Alternatives: An Overview of a Cross Generational Community Driven Practice <i>Emilio Vaca</i>	37
28	Creating Trauma Informed Care Environments: A Learning Collaborative for Youth Residential Treatment <i>Victoria Hummer, Norin Dollard & Fran Myers-Routt</i>	38
29	Addressing the Mental Health Needs of Children Who Have Witnessed Domestic Violence <i>Ilana Amrani-Cohen</i>	39
30	Needs and Services of Sexually Abused Children <i>Renee Brown & Christa Labouliere</i>	40
31	Antipsychotic Medication Utilization Among Children Prior to Out-of-Home Care <i>John Robst</i>	41
32	The National Workgroup to Address the Needs of Youth Who Are LGBTQI2-S and their Families in Systems of Care <i>Sylvia K. Fisher & Jeffrey M. Poirier</i>	42

Poster 1

Youth and Family Perspectives – Mental Health Needs Identified: Now What?

Presenting: Diana McIntosh, Julie Geiler, & Monica Mitchell

Acknowledgements: This project was funded by The Health Foundation of Greater Cincinnati.

Introduction

Programs that address mental health needs in the schools are increasingly sited as best practices for prevention and intervention. Yet, is this what youth and families desire? System driven designs, though well-meaning, can be inadequate without incorporating the youth and family perspective.

The Hamilton County Mental Health and Recovery Services Board received a three year planning grant from The Health Foundation of Greater Cincinnati to improve access to mental health services for school age youth. The first phase addressed needs from school administrators and agency staff perspectives. The second phase incorporated youth's and families' voice. The third phase designed a strategic plan to improve access to meet these needs. This poster will share the major findings from the first two phases and will highlight the resulting strategic focus.

Methodology

Participants

Phase I. Hamilton County, Ohio has 198 schools in 22 districts. The target population was school personnel inclusive of all 22 districts and 198 schools. The survey was completed by 100% percent of the districts and 80 % of the schools ($N = 157$).

Phase II. Phase I cited the highest mental health needs were in youth grades 7-12, thus guiding the decision to target five thousand 7-12 graders and their parents guardians in Phase II. The resulting participants of 2,745 youth and 486 of their parents/guardians represented diversity in age, race and economic status.

Instruments

Phase I. The SAMHSA Survey of Characteristics and Funding of Mental Health Services was administered to school personnel.

Phase II. The Ohio Scales (Ogles, 1999) were used to measure problem severity, functioning, and hopefulness. Additional items were added to measure the incidence of mental health problems and treatment, help-seeking behavior, attitudes and emotional well being, service location preference and barriers to seeking help (adapted from the Butler County survey, 2003). The result was a three-page, 93 item quantitative needs assessment survey.

Procedure

Phase I. A packet inclusive of an introductory letter, hard copy version of the SAMHSA survey, a self-addressed stamped envelope and clear instructions on alternative methods (i.e., electronic or phone) were mailed to school personnel in districts and schools.

Phase II. The Ohio Department of Education categorizes the county districts into four clusters, representing income and poverty levels. These clusters and randomized sampling were used to select which 7-12 grade classrooms to target and deliver the matched surveys (i.e., to youth and parent/guardian). Instructions requested that teachers administer and collect youth surveys in class and have students take the parent survey home to be completed. Parents could return the survey to school or by mail in a prepaid envelope. Incentives were offered to increase response rate.

Analysis

Analysis of both surveys was completed by a consultant using descriptive statistics. In Phase II, the formula predetermined by the Ohio Scales methodology and t tests were also used. Data were weighted to achieve representation of youth and parents/guardians of the county as a whole.

Findings

Phase I

- Students mental health needs were rated as high in 9-12 graders by 65% of school personnel, followed by 47% rating the needs of 7-8 graders as high.
- Social, interpersonal and family problems were rated as the most frequent problem and as the highest consumer of school resources (> 75%).
- Aggressive/Disruptive Behavior (bullying) was rated as the second most prevalent problem (> 38%).

Phase II

- Youth and parents/guardians reported the most frequent problem severity item as arguing with others. Even though parents and youth agreed on two of the top three items, youth reported them at significantly higher levels ($t(3105)=9.98, p<.001$)
- Twenty-three percent of the youth reported experiencing an emotional problem in the last six months, but less than 10% reported receiving professional mental health services.
- The first choice of treatment location for youth and parents/guardians was doctor/therapist/counselor's office, followed by home based services. Forty seven percent of the youth responded that they would never want to receive services in schools.
- Privacy (82% of youth), cost, and whether anyone could help were the most frequently reported concerns about seeking treatment, with youth reporting higher responses to barriers than parents/guardians.

Conclusion

The needs assessment suggests that youth have greater mental health needs than parents/guardians are aware of, and may not seek professional help for many of their problems. Barriers such as cost, privacy, and where the services are offered may be impacting youth's ability to seek help. In spite of the trend supporting school based services, almost half of the youth reported never wanting mental health services in schools.

Implications for Strategic Planning

As a result of these findings, a strategic focus was formulated to better engage youth in need of mental health services. Further, partnerships will be strengthened between youth, their families, mental health professionals, and other supportive individuals and services that are expected to result in improved linkages and a higher treatment engagement rate. The community stakeholders were engaged in the strategic planning process to develop action steps and timelines.

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- Ogles, B. M., Melendez, G., Davis, D.C., & Lunnen, K. M. (1999). *The Ohio Youth Problem, Functioning, and Satisfaction Scales (Short Form) Users Manual*. Ohio University.

Poster 2

Organization of Therapeutic Practices in Treatment as Usual

Presenting: Charmaine Higa-McMillan, Trina Orimoto,
Charles Mueller & Ryan Tolman

Introduction

With over 322 empirically-supported treatments available, clinicians are faced with a daunting task when selecting interventions for clients (Chorpita & Daleiden, in press). The magnitude of options and the rise of eclecticism as the modal theoretical orientation (Norcross, 2005) impede a clear understanding of “treatment as usual.” The Distillation and Matching Model offers a method for elucidating this issue. Through identification of common elements within treatment manuals, this model allows for a refined examination of the evidence-based literature and interventions utilized in usual care (Chorpita, Daleiden & Weisz, 2005).

Factor analyses conducted by Weersing, Weisz and Donenberg (2002) on strategies used by psychologists and psychiatrists (45% private practice) suggest that common therapeutic elements organize around theoretical orientation. Given that direct therapy is often provided by masters-level therapists in community settings, it is vital to investigate how common elements organize when non-doctoral therapists serve as reporters. Additionally, Weersing and colleagues (2002) studied the factor structure of treatment elements based on a self-report questionnaire. Therapists’ self-report of elements used in general practice may differ from what they actually apply with real cases. Therefore, it is valuable to study what techniques therapists truly employ with clients (versus their summary of practices). An understanding of how these therapeutic elements cluster in actual practice would further inform our knowledge of “treatment as usual.”

Methodology

Participants

The current study examined treatment data from 269 therapists representing eight provider agencies in Hawaii’s Child and Adolescent Mental Health Division (CAMHD) in the State Department of Health. All therapists provided in-home therapy services and submitted at least one Monthly Treatment and Progress Summary (MTPS; CAMHD, 2005). Therapists were from varying educational backgrounds, with 10.3% reporting a doctoral degree, 88.1% a masters, and 1.7% a nursing degree or bachelors. The final sample integrated clinical data for a single, random client from each therapist. 157 boys and 112 girls with a mean age of 13.3 years ($SD = 3.5$) were represented. 71.0% received more than one diagnosis at the start of the treatment episode.

Measurement

The MTPS was developed as a clinical report form and is submitted monthly by therapists via a HIPAA-compliant server. Information regarding intervention practice elements (PE) is detailed for every client receiving service in the CAMHD system. Therapists are asked to indicate all PEs used in the previous month from a list of 55. The PE component of the MTPS has demonstrated test-retest stability (Daleiden, Lee, & Tolman, 2004).

Analysis

Therapists’ endorsements of each practice element were examined across the completed treatment episode. Strategies applied by less than 10 therapists (8 PEs) and PEs with low reliability identified by Chorpita and Daleiden (in press; $k < .65$) were excluded from analyses. Since we were unclear about the structure of the factors, an exploratory factor analysis with varimax rotation using Mplus (Muthen & Muthen, 1998) was conducted on the dichotomous data set.

Results

While a one-factor model appeared to provide an adequate solution based on the scree plot, a four-factor model with an RMSEA of 0.027 demonstrated the greatest interpretability. Practice elements with loadings of $|\geq 0.3|$ on the primary factor and ≤ 0.2 differences between the primary factor and the other three factors were retained. An additional 19 items fell short of this criterion and were eliminated from the factor structure.

Analyses indicated that factor one represented external interventions implemented by caretakers and therapists to enhance youth compliance. This factor was inversely correlated with age ($r = -.30$) and youth with externalizing diagnoses were more likely to score higher on this factor than youth without externalizing diagnoses ($t = 2.9, p < .05$). Factor two was comprised of youth-focused strategies aimed at helping youths help themselves and was correlated with age ($r = .17$). Factor three indicated social skill development with an emphasis on educational supports. Youth involved in the CAMHD through the Individuals with Disabilities Education Act (IDEA) scored higher on this factor than youth not involved through IDEA ($t = 2.6, p < .05$). The content of factor four encompassed interventions highlighting engagement and family supports and was correlated with age ($r = .16$). Youth with substance abuse diagnoses were more likely to score higher on this factor than those without such diagnoses ($t = 2.4, p < .05$). Findings suggest that practice elements as reported by non-doctoral therapists in community settings do not appear to exclusively organize by theoretical orientation, but rather by a combination of theory and case characteristics.

Table 1
Factor Loading Matrix for Practice Elements Endorsed by Therapists on the MTPS

Practice Element	Factor 1	Factor 2	Factor 3	Factor 4
Ignoring or DRO	0.923			
Commands or Limit Setting	0.715			
Directed Play	0.650			
Time Out	0.532			
Functional Analysis	0.526			
Medication or Pharmacotherapy	0.440			
Guided Imagery		0.488		
Maintenance or Relapse Prevention		0.541		
Psychoeducational Child		0.549		
Relaxation		0.646		
Response Prevention		0.672		
Peer Modeling or Pairing			0.737	
Social Skills Training			0.726	
Modeling			0.698	
Skill Building			0.669	
Mentoring			0.601	
Therapist Praise or Rewards			0.597	
Parent Praise				0.673
Marital Therapy				0.647
Relationship or Rapport Building				0.544
Family Engagement				0.513
Family Therapy				0.447
Eigenvalues	15.009	2.997	2.447	2.306

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Poster 3

Wraparound Training of Trainers (WATOT): An Initiative to Standardize Wraparound Services in El Paso County

Presenting: Luther Marcena, Vashti Pussman, Anthony Cobos & Wes Temple

Introduction

The delivery of wraparound services currently has no standards nor certifications requirements. The County of El Paso, Texas, thru Border Children's Mental Health Collaborative (BCHMC), a SAMHSA grant graduated system of care (SOC), initiated an effort to standardize services by purchasing a curriculum used to train a group of trainers from different government, public, non-profit, and private agencies, as well as school districts at no cost. Amongst them: Juvenile Probation (JPD), Child Protective Services (CPS), Mental Health Mental Retardation (MHMR), Border Children's Mental Health Collaborative (BCMHC), Region 19, El Paso Independent School District (EPISD), Socorro Independent School District (SISD), Young Women's Christian Association (YWCA), Ysleta Del Sur Pueblo (Tigua Nation). This group will train additional trainers and facilitators using the same material, eventually creating a standardized system of wraparound services through the county.

After the initial training session was done, the group met several times to undergo additional training that included practice sessions monitored by professional experienced care managers. It was realized then that this initiative was in fact developing a standard for training of trainers and facilitators of wraparound services. This produced a new goal: to not only prepare a group of trainers that would disseminate a homogenized curriculum in wraparound delivery, but to set minimum standards of preparation/training for the County of El Paso.

Additional goals of this educational initiative include the engagement of the different school systems into applications (perhaps at a light level) that will include wraparound philosophy principles.

El Paso County Judge, Anthony Cobos (also BCMHC's Principal Investigator) is committed to the mental health cause, particularly with

young members of our community. His support for all aspects of this initiative by providing financial and assets support to this initiative is paramount to its successful completion. By actively engaging the county's government into supporting this initiative he is breaking ground in an unprecedented manner. The County of El Paso is in the process of creating a Youth Services Center that will provide youth at risk and their families with a one stop center for much needed services. BCMHC and the wraparound philosophy will play a central role in this institution.

Currently we have identified and are providing training at four levels:

- Level 1 – Introduction to wraparound: This is aimed at educating general audiences about wraparound principles and philosophy.
- Level 2 – Wraparound for participants: Aimed at people who plan to participate in a wraparound program in the near future, educating them in the principles and guidelines of the wraparound philosophy.
- Level 3 – Facilitators: Trains facilitators in the deployment of wraparound services based in the officially adopted curriculum of El Paso County.
- Level 4 – Trainers: Trains trainers that are going to prepare other individuals at all the above mentioned levels using the official wraparound curriculum of El Paso County.

Data are collected that will provide feedback for necessary changes and modifications of the curriculum and training methods as required to support evidence based practices.

This initiative is at an infant stage in its development, however, the understanding, interest and support for it by the community at large is growing at a very fast pace. Currently County Judge, Anthony Cobos, is considering proposal to the Texas legislature regarding the expansion of his initiative to the state level.

Poster 4

Wrapped and Reunited Using Wraparound to Support Family Reunification

Presenting: Irene Rickus, Chris Groeber, Eileen Youmans & Virginia Grant

Introduction

During this poster presentation, program developers from Kids Central's Intensive Reunification Program will share their program, its barriers and successes to address the needs of child welfare involved families attempting to reunify. The discussion will explore the basic concepts of wraparound and how it really fits within a typical child welfare paradigm. There will be discussion how they are measuring their successes and addressing barriers as they arise and elicit from the group of participants their ideas on program improvement. The developers will also discuss the critical nature of transition and aftercare in such an intensive program.

Kids Central Incorporated, a Florida Community Based Care organization located in Circuit 5, has developed a program to address the needs of children and their families in the reunification process. The Intensive Reunification Program (IRP) is a service that assists children (5 and up) and their families upon reunification from out of home care to live successfully in their community. The IRP provides home-based services that are intensive and supportive and based in "wrap around" methodologies. A comprehensive assessment of the family's assets and needs results in an assignment to the Program occurring at a staffing. Services are focused on the underlying family problem(s) that led to the report of suspected abuse or neglect. The project is staffed by a team in each of the five counties that will provide case management and clinical intervention.

Methodology

Intensive services are provided for approximately 90 days. Less intense, follow up and monitoring services are available for an additional 90-day period. There is also an opportunity under certain circumstances to bring families to a special staffing that will allow for up to a four week extension of the actual program. The goals and objectives of the services are clearly defined on the child's intervention and aftercare plan.

Ideal program candidates are children who are victims of abuse or neglect, are in physical custody of the State and remain at high risk of abuse, but are being reunited with their families. The children must have a mild to serious emotional disturbance or at risk of developing an emotional disturbance.

The family and program evaluation will be heavily based on family and child outcomes as measured by the North Carolina Family Assessment Scale Reunification (NCFAS-R), which is administered monthly for the families duration in the program and then again, one month post discharge to determine behavior change and sustenance. Training and clinical support is provided through a peer consultation process that engages the IR Case Managers and Intervention Specialists in regular discussions about their cases with Kids Central administrative staff.

Critical Learning Areas

- The potential impact of intensive wraparound services for families/ caregivers where the child's permanency plan is reunification
- Utilization of the NCFAS-R to measure outcomes at the family and program level
- The impact of true wraparound philosophies on the a child welfare culture
- The critical nature of aftercare planning in this time limited program
- Identifying families/children who are good candidates for this program
- Working as a team with the family, community supports, courts, child and child's Family Care Manager

Conclusions

At this date, conclusions for the project tend to be anecdotal in nature however, IR staff are reporting great success with families and initial data indicate steady improvement in the areas of Bonding, Safety, Environment, Parental Capabilities, Family Interactions, Family Safety, and Child Well-Being. Additionally, families report the interaction with IR staff to be helpful in improving their overall situations. Target children involved with the process are reporting that IR staff has helped them feel better about themselves (through creative supports such as makeovers, school help and general advocacy). Data are collected on the percent of families that remain intact, and have not returned to the system. Aftercare provisions have for many families, been realistic and actually aided in the process of the IR program ending. Families report having learned about themselves and the types of things that have caused problems for them in the past. Families receive a "follow-up" NCFAS 90 days post the project ending and they are tracked for a year after the family completes its intervention plan.

Poster 5

Examining the Relationships between Family-Run Organizations and Systems of Care

Presenting: Katherine Lazear & Rene Anderson

Introduction

A premise of this study and of system of care principles is that establishing a strong family voice is an essential element for building and sustaining of a family-driven, effective system of care (Koroloff, Friesen, et. al.1996). Often a key element for ensuring a strong family voice is establishing a strong family organization (Stroul & Manteuffel, 2007). There is a growing body of literature examining the development of family-run organizations (e.g., Briggs, 1996; Koroloff & Briggs, 1996; Lazear, Anderson, & Boterf, 2007). However, there is less research exploring the quality and nature of the relationship between family-run organizations and non-family-run organizations in systems of care (e.g., Hoagwood, Green, Kelleher, et al., 2008; Pires & Woods, 2007). This study explores the relationships and strategies of family-run organizations and non-family-run entities in developing family voice in the context of key elements articulated in the research as essential to family voice.

Key Elements Articulated in the Literature

- Families are partners in all aspects and at all levels of systems of care
- Targeted resources are in place to support and sustain the development and growth of a family-run organization to create capacity for “family voice” in shaping their community’s response to children with mental health needs and their families.
- Racially and ethnically and other culturally diverse family leaders are recruited and nurtured to interface effectively with the system of care in a variety of capacities so that it is more diverse and representative of the community it serves.
- Family members operate in a peer support role to assist other families and youth.
- A family-run organization plays a key role in ensuring families have access to needed quality of services.
- Families are engaged in changing policy.

Methodology

Six family-run organizations were nominated for participation in this study through a review process by a committee composed of family organization leaders, family members, and system of care consultants and researchers. The committee sought a diverse representation of family-run organizations and considered a number of factors in their selection deliberations.

Data collection occurred during a two-day site visit, and included semi-structured, key informant interviews with family members, family-run organization board members and staff, representatives from child serving systems, other identified system of care and community partners, and focus groups with family members.

The study used a participatory action research approach, involving family-run organization staff and family members in all aspects of the research. The study method was based on a multiple case study design.

Findings

Study findings suggest the following:

- The stronger the relationship between the family-run organization and the non-family-run entities, the more likely that key elements essential to strong family voice are realized.

- A strong family-run organization is necessary, though not sufficient, to have a strong and sustained family voice in system of care. Non-family-run entities must commit themselves to operationalizing family voice through funding for family organizations, hiring family members as staff, including family partnership in policies, and the like.
- The relationship between family-run organizations and non-family-run entities in systems of care is developmental. However, the relationship is also subject to “stops and starts” as leadership changes in both types of organizations. This is one reason why the age of a family organization does not necessarily equate to a strong relationship.
- The relationship between family-run organizations and non-family-run organizations in systems of care is complex in nature, and the strongest relationships appear to be those that are multi-textured.
- There are times that an existing family-run organization does not meet the needs of all families. When this happens, the family-run organization, in partnership with other system of care partners, needs to put mechanisms in place so that all families’ needs can be met.
- Family voice is supported when families serve in a variety of capacities within all operations of a system of care. A paradigm shift is needed from viewing families as recipients of services only to providers of information, services and supports.
- Many families view the provider array more broadly than just the traditional service providers from the public entities (i.e., mental health child welfare, education, juvenile justice, health) and include partnerships with faith-based organizations, businesses and recreational entities.
- Where families are receiving peer-to-peer support, the support may be operationalized differently across family organizations and within systems, but the common factor is that the support is family-to-family.
- There are levels and specific types of support necessary for the system of care to provide for families to successfully develop and sustain their own family-run organizations, including financial support, training, and leadership opportunities. The level of support cannot be tokenistic.
- Peer-to-peer support from other state and/or national family-run organizations appears to be an essential component for sustaining family and youth work.
- When there is only one source of funding, it may be difficult to sustain the organization over time. This is obviously true with grant funding that typically is time limited. State legislated support/funding for family-run organizations can help to provide a level of certainty and stability.
- The importance of cultural and linguistic competence is reflected in the amount of resources provided by the system of care to operationalize cultural and linguistic competence (e.g., hiring diverse family members, developing linguistically competent materials, partnering with the family-run organization to hold community activities that reach diverse families, etc.).
- Where family-run organizations are helping to ensure the type and quality of care, there are policies and practices in place throughout the system of care that encourage and support family-driven monitoring and evaluation activities.
- While advocating for children’s services and supports, family-run organizations must also continuously advocate for their own sustainability, and growth.

- A strong relationship between the non-family-run entities in systems of care and family-run organizations can lead to effective family voice in influencing legislative processes that have a bearing on children and families. The family-run organization must be seen as credible and viable to effectively advocate for policy change and participate in the policy arena.
- National or state family-run organizations can support and enhance the policy work of local family-run organizations. In turn, family-run organizations must be supported locally to engage in statewide and national policy work.
- State, local and system of care policy-making bodies must be culturally and linguistically competent for all families to have a voice at the policy table.

Conclusion

Family voice is most evident in systems of care when there is a strong relationship between non-family run entities and the family-run organization to support family voice at all levels, including: setting policies, developing programs, delivering services, and assessing the impact of the system of care.

The strength of the relationship between the family-run organization and non-family-run partners in a system of care can help to secure the family organization's developmental trajectory toward consistent growth as the engine of family voice and family-driven care.

Poster 6

Factors Affecting Long-Term Outcomes Following Intensive In-Home Services

Presenting: Sarah Hurley

Introduction

The purpose of this study was to increase understanding of the importance of multi-level factors including youth-level demographic, family, and clinical characteristics, program participation characteristics, and organizational-level variables, in determining long-term outcomes following intensive in-home services (IIHS) to address behavioral disorders. While child and family characteristics are essential factors in understanding outcomes of services, "the effectiveness of family preservation (or any other service) cannot be examined without attention to the larger service context" (Staudt & Drake, 2000, p. 647). Organizational factors have been demonstrated to contribute significantly to explaining variance within client outcomes (Yoo & Brooks, 2005). Given some of the specific features of IIHS, including delivery of services by a single counselor, highly structured supervision, and an ecological focus that directs counselors to work with all systems affecting a youth's behavior, organizational factors may shed substantial light on outcomes that are observed across a population receiving IIHS.

Methodology

The study sample was drawn from the client population of a large provider of behavioral health services in the southeastern US. All youth over 13 years of age who received IIHS as their only service from the agency, were discharged between January 1, 2001 and December 31, 2006, and completed a follow-up survey one year after discharge were included.

Youth-level measures included demographics (age, gender, race), clinical characteristics (previous involvement in juvenile delinquency, runaway behavior, substance use/abuse, behavioral disorders, emotional disorders, suicide ideations or gestures, victim of neglect, victim of physical abuse, victim of sexual abuse, and association with negative

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peers), and family characteristics including family history of psychiatric illness, substance abuse, contact with legal authorities, and domestic violence. Characteristics of program participation included year of discharge and length of service; youth were also categorized as having a primary counselor if an individual counselor conducted 75% or more of the family sessions.

Data on long-term outcomes were gathered from youth, families, or custodial agency staff via phone survey at one-year post discharge. Behavioral and functional indicators were gathered including placement at the time of follow-up, educational progress, contact with legal authorities, and out of home placements. In addition, a composite categorical measure was created. Following the procedure used by Barth et al. (2007a, 2007b), outcomes were classified as desirable if youth were living with family at the time of follow-up, making educational progress, had avoided contact with legal authorities, and had not been placed out of their home during the follow-up period. Mixed outcomes were defined as living with family at the time of follow-up, but experiencing at least one of the following conditions: lack of educational progress, contact with legal authorities, or out of home placement. Undesirable outcome was defined as not living with family at the time of follow-up, regardless of the status of other behavioral indicators.

Organizational-level variables included monthly counselor turnover, which was calculated as the number counselors who left the agency each month divided by the number of active counselors in the middle of the month (U.S. Department of Labor, 2008). Size of office was measured as the number of youth served by each office in the IIHS Program during the study period.

Due to the nested nature of the data (youth clustered within offices) and the unequal size of groups (number of youth per office), hierarchical linear modeling was used to examine the relative contribution of variables at each level to the identified outcomes.

Findings

The sample of clients included 1,593 youth served out of 20 offices; 58.8% of the sample were males, 27.5% were African-Americans, and the average age was 15.3 years. The mean number of cases served per office during the study period was 405.6 ($SD = 289.6$). Mean monthly turnover among counselors was 3.3% ($SD = 1.0\%$) across offices, and ranged from 1.53% to 5.65%.

Demographic variables played an important part in predicting long-term outcomes. Males were found to have significantly lower odds of positive outcomes. Age was a significant positive predictor of probability of positive outcomes, with the exception of educational progress; age was negatively associated with the likelihood of being in school, graduated from high school, or in GED classes. Among the clinical characteristics, only antisocial behavior was a consistent predictor of long-term outcomes. For each outcome, a higher level of antisocial behavior was predictive of higher odds of negative outcomes. Length of service also played an important role in predicting outcomes at one-year post discharge for all outcomes except contact with legal authorities. In each case, longer lengths of stay were associated with higher odds of a negative outcome.

Conclusion

Client characteristics were generally found to be more important predictors of long-term outcomes following intensive in-home services than were program activities or organizational characteristics. The findings point to the importance of strengthening program models to address specific

client-level risk factors for negative outcomes at one-year post discharge, particularly for adolescents receiving intensive in-home services.

Based on these findings, the intensive in-home services program in the study agency is most likely to improve the long-term outcomes for youth served if they concentrate their energies on high-risk clinical characteristics, rather than focusing on organizational attributes such as program size and staff turnover.

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Poster 7

Brainstorming How Research Findings in Positive Psychology Can Enhance Strength-Based Practice in Children's Systems of Care

Presenting: Ivor Groves

Introduction

From the beginning there have been efforts in the system of care (SOC) approach to address the whole child and to focus on improved functioning. SOC's were designed to create a collaborative and organized approach to working with children and families across settings to achieve positive outcomes. Positive components of the system of care principles include the following practices:

- Constructively and respectfully engage the child and family in an authentic and collaborative relationship,
- Identify and incorporate child and family strengths into intervention strategies,
- Design individualized intervention plans in collaboration with the child and family's preferences, cultural context and goals, and
- Focus as much on strengths, improved functioning and well-being as the reduction of deficits and elimination of psychopathology (Huang et al., 2005).

When families perceive that these principles are being adhered to in the services they are receiving, the greater the level of satisfaction with services and the fewer externalizing and internalizing problems are reported one year after receiving services (Graves, 2005).

Research in positive psychology is contributing a deeper understanding of how positive emotions, personal strengths and positive cognitive strategies contribute to improved functioning and greater well-being for children and adults. Using the scientific method, new assessments and interventions are being developed that can be used to enhance strength-based practice in the SOC's and to increase the efficacy of the positive components of SOC's as outlined above.

Refocusing General Practice

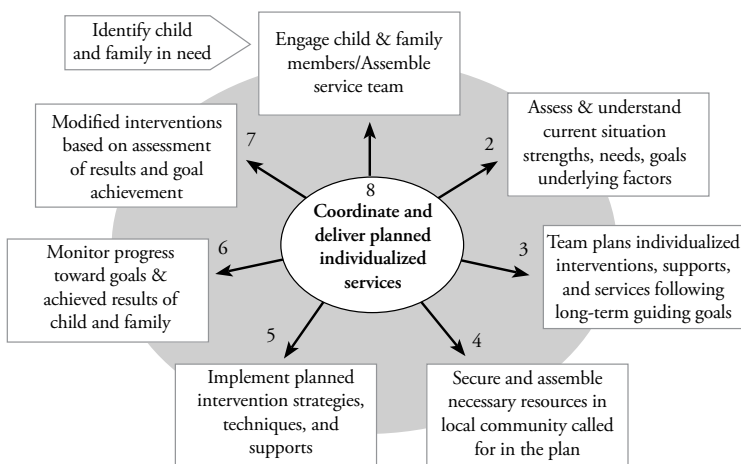
The general practice model that is used to organize and guide the planning of service intervention in child-serving human services is shown in Figure 1.

This model is generally the process that practitioners follow. The formality and explicitness increases as child and family needs become more complex and involve more individuals in the delivery of services. It would be a good exercise at the agency level and at the team level to

Figure 1

System of Care—Child Practice Model

Every function in the "spinning wheel" offers opportunity to increase the focus on the positive



examine each of the components of the practice model and brainstorm how more emphasis on positive interventions, strategies and interactions can be placed at each step of the process. For example, how can the initial intake and engagement focus more on child and family strengths? How can positive emotions be used to more effectively engage families? Or, how can outcomes be added that include positive gains in SWB, cognitive strategies and positive affect? In my role as an applied evaluator, I have examined 1000s of examples of good and not so good practice across many states and programs. Our data show that when the child team is working together in partnership with the family and when the child and family perceive that they are being respected and feel that their strengths are being engaged, positive outcomes are most likely to be achieved (see also Graves, 2005). In these best-practice examples, there is greater satisfaction and more goals are being achieved. In addition, the child team feels a sense of accomplishment and report higher job satisfaction. The child and family report that they have hope for the future.

The purpose of this presentation is to stimulate thinking and knowledge of how research findings regarding personal strengths, positive engagement, positive emotions, gratitude and positive cognitions might

be applied in SOC practice at both the client and the organizational level. The poster will include whether the goals of individualized services with a child and family should explicitly include improved subjective well-being, increased hope and optimism, and greater engagement in activities that will strengthen and build on talents, skills, passions and preferences. Participants will receive new references and web-based resources that they can use to enhance strength-based system of care practice. New avenues of research and new research opportunities will be presented.

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Poster 8

Implementing Evidence-Based Interventions in Community Mental Health: An Outcome Study

Presenting: Amy Starin & Kathryn Wehrmann

Introduction

The Illinois Department of Human Services, Division of Mental Health, Child & Adolescent Service System intensified its efforts to work collaboratively with system partners to assure the provision of a recovery-oriented, evidenced-based, community-focused, value-dedicated and outcome validated mental health services system through the establishment of the Evidence-Based Treatment Initiative (EBTI) in 2006. A key emphasis of the EBTI is training community mental health agency staff to provide evidence based interventions to the child and adolescent population.

While the current state of the evidence base shows that there is no single intervention that is appropriate for all clients and that there are many clinical situations for which there is no proven treatment, there are many interventions with impressive evidence regarding their effectiveness. Based on a survey of community mental health clinicians in Illinois, the most common presenting problems encountered by providers among child and adolescent consumers were behavior problems, mood and other psychological problems and family problems. The specific evidence-based treatments they were most interested in learning about were family and parenting models, followed by cognitive-behavioral therapy.

The intent of the evaluation study reported on in this paper was to move beyond research that has looked at evaluation of evidence-based treatments in more restrictive settings in order to assess the effectiveness of evidence-based treatments in community mental health settings where complex clinical situations regularly confront practitioners.

Methodology

Ten community mental health pilot sites were selected in keeping with the EBTI's commitment to train community mental health agency clinicians to provide evidence-based interventions to the child and adolescent population. Each site selected for the pilot documented the commitment of agency leadership by providing a plan for how they would support the inclusion of evidenced-based practice principles within the organization and its clinical culture. The training plan included

eight full-day, in-person training sessions and twice monthly telephone supervision over a full year. The trainers were nationally recognized clinicians and researchers who are local to Illinois.

Each site committed a Master's level or higher level line staff to serving eight or more cases being treated under the EBTI model and a Master's level or higher supervisor who would carry four or more cases to participate in the training. Each site also involved comparably experienced staff who, while not involved in the intervention training, participated in the evaluation process to provide a basis for comparison of treatment outcomes. In addition, pilot site agencies were asked to obtain the necessary technological resources for taping interventions with clients for review in model specific supervision, maintain or establish a relationship with a workforce training institution, and develop a plan to disseminate the learning further into their agency. During the first year of the initiative, outcomes were measured through the use of the Child and Adolescent Functional Assessment Scale (CAFAS), (Hodges, 1994) and the Strengths and Difficulties Questionnaire (SDQ), (Goodman, 1997).

Findings

Results of the evaluation based on 89 cases for which there was Time 1 and Time 2 CAFAS measure based on multivariate statistical analysis (MANOVA) was used to compare the means of dependent variables related to CAFAS scores for children and adolescents receiving treatment under three different treatment conditions including, treatment provided by clinicians trained in Cognitive Behavioral Therapy, treatment provided by clinicians trained in the Behavioral Parent Training Model, and a comparison condition where no treatment model or approach was specified. All three conditions were carried out in community mental health settings as described earlier. Evaluators controlled for between subjects effects in the MANOVA analysis by looking at Time 1 measures to determine whether there were any group differences. The major finding was that there was a highly significant difference ($p < .05$) between the experimental groups and the comparison groups based on a comparison of Time 1 (intake completion of CAFAS) and Time 2 completion of CAFAS at the eighth session or termination.

Through the analysis it was also possible to compare the areas that improved between the three groups and the extent to which they improved. Evaluators expected that there would be a change over time for all three groups. The main effect of time was highly significant for all measures except those on use of drugs and community (i.e., delinquent-like behavior), in the experimental group. Interaction with time indicates that all groups got better with some doing better than others. Change over time was greater for some factors in the experimental groups. There were statistically significant differences in CAFAS measures relating to behavior at school and moods and to a lesser extent for behavior at home.

Conclusion

The results of the statistical analysis indicate that the use of Cognitive Therapy for Children with Mood Anxiety or Externalizing Problems and Behavioral Parent Training may be more effective in addressing the commonly reported presenting problems encountered by community mental health providers than under treatment conditions where no

specific treatment model was specified. It is important to note that there may be additional factors that contributed to the differences in client outcomes as measured CAFAS. Such factors include the additional supervision in the CBT and Behavioral Parent Training models and the degree to which agencies were able to support the efforts of clinicians involved in the pilot. Evaluation work continues including the use of qualitative interviewing that may provide additional insight into the adoption and effective use of evidence based intervention models.

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Poster 9

Adoption and Implementation of Trauma-Focused Cognitive Behavioral Therapy, an Evidence-Based Practice, and Related Resources, in the National Child Traumatic Stress Network

Presenting: Angela Montanago

Contributing: Qualandria Bell, Charley Seagle, Brandee Brewer & Elizabeth Douglas

Introduction

Children's experience of traumatic events can lead to a wide range of psychopathologies and other negative consequences capable of having lifelong effects and intergenerational impact (Hubbard, Realmuto, Northwood, & Masten, 1995). Research has shown that intervention at the appropriate time can dramatically affect whether and to what extent children and adolescents recover from trauma (Goenjian, Karayan, & Pynoos, 1997); however, even in the case of treatments found to be effective, the protocols are not necessarily implemented consistently and are not being translated into practice often enough (Silverman, Kurtines, & Hoagwood, 2004).

The National Child Traumatic Stress Initiative (NCTSI) funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) is positioned to play a pivotal role in supporting the translation of research to practice in addressing child traumatic stress. Since its inception in 2000, nearly 80 centers located in academic and community treatment settings—collectively, the National Child Traumatic Stress Network (NCTSN)—have been federally-funded to develop and implement trauma-informed interventions, to disseminate information about child trauma (e.g., medical trauma, sexual abuse, physical abuse, domestic violence and neglect) and evidence based practices (EBPs), and to facilitate collaboration among the centers and among child-serving systems. The cross-site evaluation of this initiative, also SAMHSA-funded, is an important aspect of the NCTSI that examines network functions, impact, and outcomes related to multiple domains of center and network activity.

This presentation reviews cross-site evaluation findings from a qualitative study conducted in 2008 that included 67 in-depth interviews with NCTSN administrators and clinicians regarding adoption and implementation of three types of resources:

- Trauma-focused cognitive behavioral therapy (TF-CBT), an evidence based practice;

- The core data set, a collection of client assessment measures; and,
- The learning collaborative training methodology, a year-long training approach designed to promote adoption of state-of-the art knowledge and practice through clinical skills training and organizational transformation.

Research related to diffusion of innovations (Rogers, 2003; Silverman, Kurtines, & Hoagwood, 2004) and EBP implementation (Fixsen, Naoom, Blase, Friedman & Wallace, 2005) influenced the study approach to examining contextual factors that facilitate or hinder EBP implementation on multiple levels (e.g., individual, organizational, community and national). Sample research questions include:

1. Which individuals (e.g., managers, clinicians, or consumers) are involved in the adoption/implementation process?
2. What methods are used in introducing EBP's to be adopted and implemented?
3. What are the factors that facilitate or hinder the implementation of EBP's?
4. What aspects of EBP's are associated with adoption/implementation?

The information obtained through this study is designed to enhance understanding of the pathways through which adoption and implementation occur, common barriers, and best practices leading to successful adoption and implementation. Discussion will address applicability of the findings to a variety of community mental health service settings and contexts.

Methods

The interview is semi-structured and designed to elicit information related to the following domains: practice implementation history and status, organizational culture, internal support infrastructure, past experience, and staff attitudes. Through use of a team-based qualitative analytic approach, the narrative responses of respondents have been analyzed to assess underlying themes regarding adoption and implementation.

All analyses of interview data were conducted using the software package ATLAS.ti 5.2.9 (Muhr, 2004). The first phase of analysis involved a data inventory to assess emerging themes followed by the selection and categorization of text to organize responses according to themes. The initial categories were developed by trained analysts from Macro International and were based on the study's research questions, the interview guides, and the preliminary data inventory. In the second phase of analysis, the segments of text aligned with each general theme were compiled and responses were examined within categories, which resulted in additional sets of themes. Themes associated with both categories and subcategories will be reported.

Findings

Preliminary thematic analysis of AIFI data indicates that factors facilitating the success of TF-CBT implementation include (1) organizational culture/support for evidence-based practice; (2) center leadership; (3) combined training, supervision, and peer support; (4) support of TF-CBT developers; (4) relevant past experiences; and (5) clinical effectiveness of TF-CBT. Challenges to TF-CBT implementation include (1) resistance to evidence-based practice/clinician resistance; (2) challenging clinical cases; (3) lack of appropriate clinical supervision; (4) need for additional materials to guide implementation in diverse circumstance; (5) vicarious trauma among clinicians; and (6) staff turnover.

Conclusions

Initial results suggest that training offered by the NCTSN, particularly the learning collaborative training model, has positively impacted the implementation of TF-CBT among NCTSN affiliated

staff and partners. In terms of overall grant impact, according to many respondents, TF-CBT implementation would not have been possible without the SAMHSA grant and associated Network support, including the training and technical assistance available to funded centers. Among areas for improvement, while technical assistance following a training or consultation was identified as a critical resource supporting implementation, results also suggest that this resource is not always provided or available, and that its absence is one of the most significant challenges to successful EBP implementation and sustainability.

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Poster 10

Together Facing the Challenge: Enhancing and Adapting Evidence Based Principles for “Real World” Practice—A Therapeutic Foster Care Toolkit

Presenting: Maureen Murray, Kelly Kelsey, Elizabeth Farmer & Barbara J. Burns

Introduction

This poster presents results of a five year NIMH-funded study of treatment foster care in North Carolina. Treatment Foster Care (TFC) is one of few community-based treatment options for youth that is viewed as evidence based (Chamberlain, 2002; Chamberlain & Mihalic, 1998). Trained treatment foster parents work with youth in their homes to provide a structured, therapeutic environment while also providing opportunities for the youth to live in a family setting and learn how to live, work, and get along with others.

Findings from research conducted by Patti Chamberlain and colleagues on TFC and previous research by our group on “usual care” TFC suggest key elements that are associated with better outcomes for youth (Chamberlain, 2002; Chamberlain, Leve, & Degarmo, 2007; Chamberlain & Mihalic, 1998; Chamberlain & Reid, 1998; Farmer, Murray, Dorsey, & Burns, 2005). Central among these elements are: (1) supportive and involved relationships between supervisors and treatment parents, (2) effective use of behavior management strategies by treatment parents, and (3) supportive and involved relationships between treatment parents and the youth in their care.

Our study brings together the strengths of evidence based treatment with the realities of practice to examine an enhanced approach to

meeting the needs of youth being served in TFC across the state of North Carolina. We incorporated the key elements associated with better outcomes for youth and overlaid the elements included in Chamberlain's model to develop a practice- and research-informed enhanced model of TFC to use in existing TFC agencies in an attempt to improve overall quality of TFC.

Method

The intervention component of the study was based on a train the trainer model designed to increase both staff and treatment parent skills, knowledge, and competence by providing them with additional training using our enhanced model, the Therapeutic Foster Care Resource Toolkit. The intervention included the following components: in-person training with TFC supervisors, in-person training with TFC parents, and follow-up consultation, training, coaching, and support. The initial two full days of training for staff was used as an opportunity to engage these individuals in the approach and to prepare them to work intensively with their treatment foster families. The workshop led them through an accelerated version of the parent management training developed for the treatment parents and laid the foundation for our partnership. One of our goals was to provide them with the needed information and training to enable them to co-facilitate the parent sessions with the families on their caseload.

The parent training consisted of a structured 12 hour (6 session) curriculum developed to address the needs of treatment foster parents by

teaching specific parenting strategies and techniques to use in their work with youth in TFC. In addition, booster sessions for treatment parents were conducted at six months and one year post initial training. These sessions were designed to offer additional training in specific content from the curriculum that had been identified by both staff and treatment foster parents as being in need of further review and practice.

Once the initial training with agency staff and treatment foster parents was completed, a follow-up consultation with agency staff was a critical component of the intervention. The structured session format began when the parent training ended and continued over a period of one year. The goal of this component of the training was to teach, support, and coach the agency staff in implementing the parent training skills and techniques covered in the training for their direct work with treatment foster families.

Findings

This poster focuses primarily on the training program and its implementation. Training was conducted with eight agencies. Within these agencies, 70 supervisors and 350 treatment parents participated in training. Data from fidelity assessments (submitted separately for oral presentation at the present conference) show that, after training, agencies in the intervention group showed significantly better implementation of key program elements than did control agencies.

Conclusion

Improving practice in existing agencies is a critical part of improving the overall quality of treatment for children. This work examines the

format and implementation of such an approach with a variety of “real world” TFC agencies. Findings suggest some challenges of conducting such work and their influence on practice as well as the potential for change in such agencies.

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Poster 11

Relationships Between Child and Family Strengths and Child Outcomes

Presenting: Marleen Radigan & Rui Wang

Introduction

The New York State Office of Mental Health (NYS OMH) Waiver serves children who are at risk of out-of-home placement. Providers use the Child and Adolescent Needs and Strengths (CANS-MH) to assess the strengths and needs of children and families to help with treatment planning. The CANS-MH consists of six domains: problem presentation, risk behavior, functioning, care intensity & organization, caregiver/family needs and strengths and child strengths. Each domain has multiple dimensions (up to 10). This study utilized the CANS-MH to examine relationships between child and family strengths and child outcomes in mental health, functioning, risk taking and care intensity during the course of receiving waiver services. Web-based reports are being developed using these results to display the prevalence of needs and needs met on the CANS-MH so that NYS OMH Waiver providers can benchmark their population and the effectiveness of their services against other service providers across the state.

Methodology

Study Design and Population. This is a retrospective study using administrative data maintained in the NYS OMH Child & Adult Integrated Reporting System (CAIRS). A large population of children completed an episode of Waiver services ($N = 3,591$) during the study period (1/2002-9/2008). Records of children who had at least one CANS-MH ($N = 1,377$, 38%) were extracted to examine the prevalence of CANS-MH strengths and needs. Outcomes were examined for a subset of children ($N = 996$, 72%) who had at least two CANS-MH records.

Analysis. Prevalence of strengths and needs on CANS-MH dimension were examined using the first assessment completed during a service episode. Relationships between child and caregiver strengths and needs met on problems, risks, functioning, and care intensity dimensions were examined using independent chi-squared analyses and multivariable logistic regression models. Multivariable models controlled for Waiver length of stay, age, gender and time between first and last CANS-MH assessments. Strengths were defined at the beginning of the episode as a score of 0 or 1 for child strengths and as a 0 for caregiver strengths. The total number of child strengths (range = 0-9, mean = 4.03) and family strengths (range = 0-8, mean = 3.3) were calculated. Needs met were calculated using the first and last CANS-MH (at least 31 days after the first) on youth during a service episode. Needs met on a dimension was defined as the change from a score of 2 or 3 (*Actionable Needs*) on first CANS-MH to a score of 0 or 1 (*Monitor/No Needs/ Strength*) on last CANS-MH.

Results

Child strengths in well-being were associated with a nearly two-fold increase in having needs met on anti-social behavior (Unadjusted OR: 1.98), trauma (Unadjusted OR: 1.71), and oppositional behavior (Unadjusted OR: 1.40). Caregiver strengths in supervision were associated with having needs met on oppositional behavior (Unadjusted OR: 1.39), antisocial behavior (Unadjusted OR: 1.74), family functioning (Unadjusted OR: 1.53), school achievement (Unadjusted OR: 1.47) and service permanence (Unadjusted OR: 1.72). Number of caregiver strengths predicted having needs met in service permanence (OR: 1.23), and family functioning (OR: 1.25) using multivariable

logistic regression models. Number of child strengths predicted having needs met school achievement (OR: 1.23), family functioning (OR: 1.19), adjustment to trauma (OR: 1.24), attention deficit (OR: 1.31), depression (OR: 1.21), oppositional behavior (1.21) and risk of danger to other (OR: 1.26) using multivariable logistic regression models.

Conclusion

This study found that child and family strengths were related to child behavioral, service needs and psychosocial positive outcomes as measured by the CAN-MH. This conclusion reaffirms the usefulness of

the CANS-MH as an effective retrospective tool for system planning. In addition, the results from the CANS-MH are being incorporated into a web-based application with reports that benchmarks CAN-MH provider data against statewide results. These reports allow OMH to leverage the CANS-MH as a retrospective tool to monitor and build the system of care for children's mental health. Future work will focus on the prospective use of the CANS-MH to better understand how child and family strengths are incorporated into service planning to achieve better child outcomes during the course of intensive services such as the Waiver.

Poster 12

Intensive Community Based Service Grant: Preliminary Outcomes

Presenting: Shweta Chandra

Introduction

This presentation will present preliminary findings of a new initiative to develop intensive community-based services to youth and their families. Section 6063 of the Deficit Reduction Act of 2005 authorized up to \$217 million to demonstrate that youth with serious emotional disturbances can be served cost effectively through home and community based services as an alternative to psychiatric residential treatment facilities (PRTF). The resulting five year grant was funded by the Centers for Medicare and Medicaid in nine states. Based on system of care (SOC) core values and principles (Stroul & Friedman, 1994), services are provided through child and family wraparound teams and include interventions that may not be available through a traditional Medicaid plan.

Building on developing local systems of care, Indiana began enrolling youth in grant services in January 2008. From January and September 30, 2008, 118 youth were identified and began grant services in 22 of 92 counties. The goal is to develop intensive community based services statewide. Six months earlier, in July, 2007, through a multi-system assessment, the Child and Adolescent Needs and Strength (CANS) (Lyons, 1999) was implemented statewide in the public mental health system and then introduced to residential services in 2008. The CANS considers multiple domains: child's strengths, life functioning, behavioral health needs, risk behaviors and caretaker's needs and strengths. Identified needs and strengths are used to develop individualized intervention plans; patterns of ratings form algorithms which help make decisions about the appropriate intensity of services.

The demonstration grant asks if targeted youth can be maintained in the community and experience stable or improved functioning. While the grant evaluation will consider how the intervention affects clinical outcomes (Stephens, Holden & Hernandez, 2004) by exploring changes in outcomes, child and family satisfaction, fidelity to wraparound and costs, this preliminary study explores changes in outcomes of youth who have received services during the first nine months of the grant.

Methodology

CANS ratings are collected at entry, every six months of service and at discharge. For the purpose of this presentation, participants who have completed CANS assessments at admission and at reassessment are included. The purpose is to examine whether there is a significant change in the level of needs or strengths of the youth from admission to the first reassessment.

Thirty six youth had their first reassessment by October, 2008, and were included for preliminary data analysis. The time interval between assessments ranged from 2 to 7 months, averaging 5 months. All youth included in this study are from Indiana and have CANS recommendation for a PRTF level of care.

Clinical outcomes for each youth are determined as significant change in any of the CANS domains. Change is determined using reliable change indices (RCI) for each CANS domain. Domain scores were calculated by averaging domain items, dividing by the number of items, and then multiplying the resulting rating by 10. Subsequent analyses will consider both improvements and no change in outcomes. Over time, the study will focus on changes for an episode of care. Grant outcomes will be compared with outcomes for youth receiving usual public mental health services.

Findings

Demographic characteristics of the sample are as follows. The age range of the participants is 8 to 18 years with mean age of about 13 years. The majority of the participants are male (69%). Eighty six percent are Caucasian and approximately 8% are African American. Most youth are non-Hispanic (95%).

Fifty-six percent of the youth improved in at least one domain. Approximately 20% of the youth improved significantly on the Child Strength domain, 25% of the families had improvement in the Caregivers' Needs and Strengths domain, 42% of the participants had significant improvement in the Functioning Domain, 33% of the youth had significant improvement in the Child Risk Behaviors, and 31% of the youth had significant improvement in the Child Behavioral Health Needs.

Chi-square analysis show that clinical outcomes did not vary as a function of gender, race, and ethnicity with one exception. There is significant difference between Caucasian and African American youth with respect to Functioning Domain outcome scores, $\chi^2 (2, N = 36) = 8.129, p = .017$. This result may seem meaningless at present owing to the small sample size; however, can be explored further with a larger sample.

Conclusion

The findings suggest that intensive community-based services are effective in increasing the level of strengths in majority of youth. This finding is hopeful as other studies suggest that strengths predict placement and help different subpopulations of youth (Epstein, Dakan, Oswald, & Yoe, 2001). Continued analysis over the duration of the grant is needed to determine if preliminary improvement trends continue. Youth who are maintained with little to no change will also be examined. What is the relationship of strengths to improvements in functioning and decreased risk behaviors? Will improved strengths, functioning and decreased risks make it possible for youth with continuing severe behavioral health needs and their families to be sustained in the community? This demonstration may help to better identify which youth benefit from intensive community based services.

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Poster 13

Identification of Strengths in Children: Use of Evaluation Data to Improve Services

Presenting: Michael Taylor

Introduction

For the past decade, communities have been funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS) to implement coordinated systems of care to improve services and outcomes for these children and their families. This study explores the use of evaluation data to improve services planning and communication between families and professionals (Taylor, 2002).

The Behavioral and Emotional Rating Scale (BERS; Epstein & Sharma, 1998) is used in this study to explore areas of both agreement and difference between professionals and family members in their assessments. The BERS was designed to support more positive engagement of children and their families, identify what is going well in the child's life, and establish positive expectations for the child. The complexity of challenges facing children with serious emotional disturbances (SED) and their families includes a fragmented service delivery system, inadequate insurance coverage for home and community-based care, and difficulty with access to flexible and individualized services. Progress has been made through federal funding and community investments in enhanced systems of care, but the lag between recognition of the needs and a sustainable systemic response continues to result in stress and isolation of families and negative outcomes for children. Early identification of both strengths and needs is posited to increase communication between families and professionals and lead to more positive outcomes.

Methodology

This study explores strengths-based practice constructs through an analysis of measurements of functioning, behavior, and strengths of the child from two perspectives. A goal of this evaluation protocol was to increase family participation through an assessment that includes simultaneous assessment of strengths by both the family and professional care coordinator.

The BERS is used in this study to examine the level of strengths identification as well as concordance between the parents' and professionals' assessments of strengths. The BERS is an empirically derived scale designed to identify strengths across the domains of Interpersonal Strength (IS), Family Involvement (FI), Intrapersonal Strength (IaS), School Functioning (SF) and Affective Strength (AS) (Epstein & Sharma, 1998). In the study the BERS strengths instrument was completed by both the therapist and parent during the assessment period, allowing a statistical analysis of differences in strengths

identification from the perspectives of the therapist and the family and comparison with national norms reported by Epstein & Sharma (1998).

Findings

While professionals have been increasingly exposed to training on strengths assessment, previous research suggests that families more often identify strengths of their child compared to professionals (Collins & Collins, 1990). Previous research by Friedman, Leone, and Friedman (1999) found that parents and professionals identify strengths, but in different domains measured by the BERS. An a priori expectation was that professionals trained in wraparound practices may identify more strengths in specific domains, such as the affective or interpersonal domains.

Parents' and professionals' ratings of strengths across the domains measured by the BERS were analyzed for strength and direction of the concordance. Three of the five subscales approach or exceed a correlation of .50 indicating above moderate agreement between parents and service providers according to Cohen's (1988) criteria. This concordance between parents' and professionals' ratings on the same subscale of the BERS, as seen in Table 1, is substantially greater than for other combinations of subscales, supporting the validity of the subscales (Epstein and Sharma, 1998).

Table 1
Concordance Among the Five BERS Subscales for Parent and Therapist

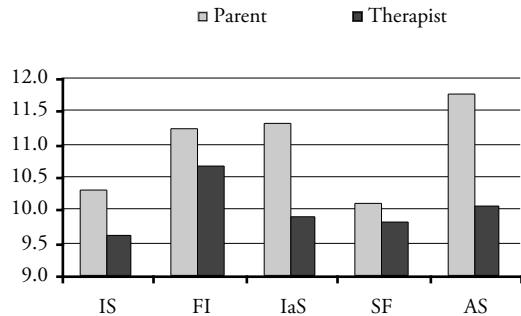
Therapists	Family				
	Interpersonal Strength	Family Involvement	Intrapersonal Strength	School Functioning	Affective Strength
Interpersonal Strength	.456**	.377**	.281**	.305**	.341**
Family Involvement	.392**	.562**	.305**	.278#	.465**
Intrapersonal Strength	.351**	.400**	.329**	.164	.251*
School Functioning	.287**	.202	.026	.637**	.105
Affective Strength	.410**	.467**	.329**	.245*	.416**

* $p < .05$; ** $p < .001$

To analyze the differences in therapists' and parents' strengths scores, a repeated measures analysis of variance (ANOVA) was used to examine differences in mean standard strength scores, primarily to examine rater by subscale interactions, as illustrated in Figure 1. There was significant main effect due to Rater [$df(1, 84) = 12.36, p = .001$] across all scales. Parent raters had significantly higher ratings of strengths compared to therapists on all scales. Scale main effects were significant [$df(4, 336) = 7.49, p = .000$] supporting the discriminant validity of the subscales. The mean scores of Family Involvement (FI) and Affective Strengths (AS) generally were the highest of the overall combined ratings and the School

Functioning Subscale (SF) the lowest. The Rater x Scale interaction effect was significant [$df(4, 336) = 6.93, p = .000$] (see Figure 1). The difference between therapists and parents was greatest on the Intrapersonal Strength (IaS) and Affective Strength (AS) subscales. The smallest difference was on the School Functioning (SF) subscale.

Figure 1
BERS Rater by Subscale Scale



Conclusions

Measurement of strengths from multiple perspectives supports the practice of including parents in assessment of their children using empirically tested instruments. The data also supports an expectation that families will bring unique information to the assessment process and challenges a bias that families stressed by children with emotional and behavioral problems may not identify strengths at the level observed by professional helpers. Gathering and comparing BERS data can enhance communication about the strengths of the child and provide a richer source for discourse about the child's needs. Often, measurements used in program evaluation are not routinely integrated in the day-to-day work of the clinician nor shared with the family and child.

Sharing assessment data enacts an approach recommended by family researchers and advocates, one in which the family's input is sought and valued at all levels. This practice enacts a paradigm shift from the traditional view of the mental health professional as the expert, with power differentially weighted to the professional and often denied to the family (DeChillo, Koren & Mezera, 1996; McCammon, Spencer, & Friesen, 2001). Families and professionals are interdependent in completing assessments and planning care on behalf of children with SED, and listening to families is critical to developing genuine mutuality, shifting from a traditional stance of power and authority to one of

mutual agreement, rapport and effectiveness (Collins & Collins, 1990; Heflinger & Bickman, 1996). This study provides empirical support for increasing the influence of caregivers' perspectives in assessments of both strengths and problems. This approach provides a method for program administrators to assure direct service providers have included families in assessment and identification of strengths and are included as an essential component of that assessment.

Inclusion of families in assessment and treatment planning, focusing on strengths, and providing flexible and effective services and supports to children are critical practice principles needed to sustain improved services to children and families. Inclusion of families in assessment and treatment planning, focusing on strengths and providing flexible and effective services and supports to children in the community are critical to reduce reliance on institutional care that may result in the child's removal from their home and community.

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Poster 14

Redesigning a Neighborhood System of Care in the South Bronx

Presenting: Jessica Fear, Neil Pessin & David Lindy

Introduction

The concept of a “system of care” has been talked about since the early 1980’s. Yet true implementation of such a system is difficult to achieve for many organizations, with attempts to organize and integrate services occurring in various regions of the United States. In 2004 the Visiting Nurse Service of New York’s Community Mental Health Services division (VNS CMHS) was invited by the New York State Office of Mental Health (OMH) to take control of the operations of one such project—the FRIENDS Program—initially a Federal SAMSHA system of care grant implemented in the Mott Haven neighborhood in the Bronx. Currently, the FRIENDS program is one of an array of separately funded yet complementary children’s mental health programs all providing services out of the same facility in the South Bronx. Each program functions under a separate funding stream, and is contracted to offer a discrete mental health service with corresponding outcomes to this very needy population. After several years of operating in this traditional manner, it became clear that the families served would receive more collaborated, comprehensive, seamless and thorough care if the programs functioned not as independent entities, but as an integrated system. This poster will illustrate our initial attempt, along with further plans, to integrate each of these distinct children’s programs into one comprehensive system of care aimed at meeting the mental health and psychosocial needs of the families in this vastly underserved community.

Methodology

The families in the Mott Haven and the other surrounding neighborhoods of the Bronx face a multitude of social and economic challenges. In 2006, the New York City Department of Health & Mental Hygiene issued a series of Community Health Profiles; including one covering Mott Haven and Hunts Point, Bronx. Based on this study, 44% to 58% of children living in this region live below the poverty level, and its population of 122,875 includes more people younger than the city’s average age (35% vs. 24%), more Latino residents (73% vs. 27%), and general health as rated in the bottom 10 of 41 rated neighborhoods. Out of 42 neighborhoods rated on their access to medical care, Mott Haven ranks nearly at the bottom. Compared to city averages, there are higher rates of drug/alcohol abuse, mental illness, and HIV/AIDS in resident adults, 10% of whom report “serious emotional disturbance.” In 2008 the Citizen’s Committee for Children of New York evaluated all of New York City’s community districts, and established that the children and adolescents in Mott Haven and the surrounding community districts are comparatively at the highest risk in categories such as poor school attendance and school performance, and rates of juvenile delinquency, child abuse and crime.

Out of one facility in the South Bronx, there are six distinct children’s programs serving this very needy population, each with their own government or private funding source. Programs range from intensive, short-term, in-home crisis intervention services to longer-term home-

based treatment and case management to school-based mental health assessment and referral services to outpatient mental health clinic services. With overlapping catchment areas, families served by any one of these individual programs were often internally referred back and forth between the various services to address specific needs of the children and families as they arose. As our array of services has widened over time, our goal has always been to integrate these discrete programs into one coordinated, integrated system of care to seamlessly serve the families in the community, while at the same time focusing on implementing evidence-based practices and tracking treatment outcomes for the clients we serve.

Findings

The initial and overarching challenge to creating our own system of care was determining how to functionally integrate several independently operating programs, each with separate funding sources and contracts, separate policies and procedures, charting requirements, specific client outcome measures, and dedicated staff positions. This poster will highlight some of the specific struggles we have encountered or anticipate encountering on the road to implementing this integration including: cooperation and buy-in from the government and private funding sources; securing ongoing funding for some programs; Medicaid reimbursement challenges; coordinating treatment methodologies between programs; staff buy-in; implementing best practices and quality assurance measures across programs; staff recruitment and retention, particularly child psychiatrists; data collection and management; outreach and engagement of referral sources; satisfying referral and admission criteria for each independent contract; serving disparate client age groups; and limitations in treating the mental health needs of the clients’ parents.

Additionally we will include data related to client outcomes such as scores from the Youth Outcome Questionnaire (YOQ), Peabody SFSS (17 Question version), Caregiver Strain Scale and school attendance data.

Conclusion

Since taking control of the FRIENDS operation in 2004, we have learned many lessons about what works and what doesn’t when trying to establish an integrated mental health system in a grossly underserved community. We have attempted to build a neighborhood-based clinical service and coordinate thorough care in a city where cooperation from different governmental organizations is often difficult to come by. With a careful eye toward thoroughly assessing the needs of the families we serve, we have developed a neighborhood system of care that offers a wide array of services aimed at meeting the complicated mental health and psychosocial needs of the children and families in the South Bronx. Our hope is that the presentation of our efforts will help illuminate one method of creating a system of care out of individual programs. The evaluation of the successes and challenges in this project will offer other agencies and policy makers the opportunity to build on effective strategies and avoid similar pitfalls when attempting to model systems of care in other neighborhoods.

Poster 15

Communicating System of Care Results

Presenting: Vicki Effland, Courtney Kasinger & Ayesha Bajwa

Introduction

Stroul and Manteuffel (2008) identified the use of evaluation data to document the effectiveness of systems of care as an important strategy for sustaining systems of care. Several sites included in their study, however, “were unable to effectively translate evaluation data into a form that was helpful in making the case for sustainability” (p. 230). Therefore, it is important not only to have a mechanism for collecting outcome data, but for effectively communicating those results as well.

Diffusion theory (e.g., Rogers, 2003) provides a framework for understanding where individuals are in adopting a new innovation, such as systems of care, and identifies the communication channels that should be used for individuals at each stage of change. Specifically, audiences that are at later stages in the process of adopting a new innovation require confirmation that the decision they have made to adopt is the correct one. On the other hand, audiences that are in earlier stages of the adoption process need to gain knowledge and awareness about the innovation.

Data Collection and Analysis

Choices, Inc. uses the Child and Adolescent Needs and Strengths (CANS) assessment as its primary clinical assessment and outcomes tool (Lyons, 2004). Care coordinators rate several dimensions of youth functioning (e.g., child strengths, life domain functioning, behavioral and emotional needs, caregiver needs and strengths) using the CANS every 90 days during a youth's enrollment. Data is entered into Choices' electronic database, The Clinical Manager, and analyzed by members of Choices' outcomes and evaluation team. Additional data on youth functioning in home (e.g., living arrangements), at school (e.g., attendance) and in the community (e.g., involvement with the juvenile justice system) are also captured in TCM.

Developing Effective Reports

In 2008, Choices was asked to provide outcomes reports for two of its sites—the Dawn Project and Maryland Choices in Baltimore City. Specifically, the local funders in each community wanted a report that summarized outcomes during the past fiscal year. To begin development of each report, members of Choices' communication team and outcomes and evaluation team met with project directors to obtain information about the context for the report and to develop a strategy for completing the report.

Through these conversations, several key differences between the identified audiences and the overall goals for the reports emerged. First, the intended audience for the Dawn Project report consisted of child welfare, juvenile justice and education representatives who were quite familiar with the Dawn Project. Almost all of these representatives would be in the trial or adoption stages of the diffusion model (Rogers, 2003). In contrast, the intended audience for the Maryland Choices report consisted of local and state policy makers. Specifically, Maryland Choices' funders wanted a report which they could distribute to various government officials to educate them about the effectiveness of systems of care. Thus, the end users of this report were in the awareness and interest stages of the diffusion model.

In order to meet the needs of these two different audiences, messages consistent with their stage of change were needed. For the Dawn Project, the appropriate message needed to provide information to confirm the decision to adopt systems of care. Results needed to be based on solid data and clearly indicate whether youth and families benefited from participating in the Dawn Project. Little information on systems of care was necessary to provide context for the report. The report for Maryland Choices, however, had to introduce readers to systems of care, Maryland Choices and its structure, and communicate outcome results. Because the primary audience was in the early stages of the diffusion model, the overall message had to focus on providing information and raising awareness about the need for systems of care, in addition to providing the data necessary to demonstrate effectiveness. The resulting reports were similar in length, but the Dawn Project report had a greater focus on results, addressing a broader range of outcomes, while the Maryland Choices report contained more diverse content, including background information on systems of care and Maryland Choices and a youth success story.

A second difference between the intended audiences was their level of familiarity with the CANS. The Dawn Project's funders had recently requested and participated in a CANS training that prepared them to be certified raters of the assessment. However, Maryland Choices' current funders had not been trained on the CANS, and the policy makers, who the report would ultimately be given to, were likely to not know about the CANS at all.

The communication of results in these two reports differed greatly because of this distinction. In the Dawn Project report, outcomes could be reported in terms of met needs on specific items, using item names and the common understanding of what it means to meet a need on the CANS. For Maryland Choices, however, the results had to be put into a format that would be understandable to a broader audience. This required in depth discussion between the communications, outcomes and evaluation and project staff so that the original meaning of the data would not be lost, while presenting information without jargon.

Lessons Learned

Reflecting back on the process used to develop these reports, two primary lessons learned can be identified for use in future collaborations within Choices and by other systems of care. First, the diffusion theory was invaluable in developing an appropriate message in both content and language. Second, a variety of staff and partners need to provide input. The program director knows the audience; the researcher knows the data and communication staff can help craft the message to specific audiences.

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Poster 16

Using the System of Care Practice Review (SOCPR) as an Ongoing Tool for Program Improvement

Presenting: Keren Vergon, John Mayo & Beth Piccora

Introduction

Success for Kids & Families, Inc. currently has a contract with the Florida Department of Children and Families to demonstrate the state pilot program for consumer directed care. Success for Kids & Families provides coordinated access for children's mental health services, assessment, triage, and family support planning. The program generally works with families for a period of three to six months. The Administrative Services Organization of the Children's Board of Hillsborough County administers the funds.

Success for Kids & Families, Inc. is based on a system of care philosophy in which a comprehensive, coordinated, community-based system of care brings together all agencies and resources needed to provide services to children and their families with mental health needs. Success for Kids & Families, Inc.'s decision to use the System of Care Practice Review (SOCPR; Hernandez, Worthington, & Davis, 2005) presents special challenges. The SOCPR was developed to measure a system's performance against an ideal system of care. Unlike many groups that use the SOCPR to assess implementation of system of care values and principles in a community, Success for Kids & Families is only part of a system of care. Thus, some system aspects are beyond the program's ability to change. In addition, due to structure and funding requirements, Success for Kids & Families faces challenges in adhering to all aspects of system of care values and principles. Fiscal year 2007-2008 was the first year of the contract, and a series of SOCPR cases were completed. Success for Kids & Families developed an action plan to address recommendations from the report. As the contract continues, additional cases are being completed, and the action plan is being implemented. The evaluator and providers at Success for Kids & Families are working in partnership to use the SOCPR for program improvement while being realistic about those aspects of system of care values and principles that are fiscally, structurally, and practically challenging to implement.

Methodology

This study utilized a case study methodology to obtain information from families, informal helpers, and their formal service providers concerning service planning, service delivery, child and family progress, and satisfaction with services. Nine families living in Hillsborough County, Florida, and their formal providers and informal helpers participated in this study. The identified primary caregiver and children (10 years of age or older) from each family participated in the study. A total of four youth were interviewed. One informal helper was interviewed. A female caregiver was interviewed in each case; a male caregiver also participated in the caregiver interview in two cases. In one case the female caregiver was a grandmother, while the rest were mothers. Five youth were male and four were female. Seven families were Caucasian, one was African-American, and two were identified as Hispanic, with Spanish being spoken in the home.

The System of Care Practice Review-Revised (SOCPR-R) was adopted by Hernandez and colleagues for this case study. The SOCPR measures a program or system's adherence to system of care core values (child-centered and family focused; community based; and cultural competence) and its derived guiding principles. In addition, a final domain, Impact, was added to measure whether services provided to families were appropriate to their needs and strengths and whether children and families improved as a result of their services provided by Success for Kids & Families. A family is the unit of analysis in an SOCPR study.

A rating that ranged from 1 to 7 was derived for each domain of the SOCPR. Scores from 1 - 3 represent lower implementation of a systems of care (SOC) approach, and scores from 5 - 7 represent enhanced implementation of SOC principles. A score of 4 indicates a neutral rating—lack of support for or against implementation was present.

Findings

The overall mean score at the case level falls on *Agree Slightly* ($M = 5.61$, $SD = 0.79$). This indicates that overall, Success for Kids & Families, Inc.'s services operate at an enhanced level of implementation of system of care values. As shown in Table 1, mean scores reveal that the program performed best in the Child-Centered Family-Focused domain, followed by the Impact domain.

Table 1
Success for Kids & Families, Inc.'s Mean Scores

	Mean	Standard Deviation
Domain 1: Child-Centered, Family-Focused	5.96	0.72
Domain 2: Community-Based	5.71	1.23
Domain 3: Culturally Competent	5.04	1.07
Domain 4: Impact	5.72	0.64

Overall Score — All Cases: 5.61 (0.79)

The Community-Based and Culturally Competent domains follow. Ratings were in the enhanced range overall, with all domain means above 5.0. Standard deviations of 0.64-1.23 show variability in implementation, with some cases showing higher levels of implementation while others evidenced more room for improvement.

Conclusion

Success for Kids & Families, Inc. is demonstrating a system of care approach to service delivery. Child and family strengths are identified and serve as building blocks for service delivery. Caregivers, and in most instances the youth, participate as partners in service planning and delivery. Access to services is high, and services are offered at convenient times and in convenient locations for families. Thorough assessments for service planning and delivery are often performed, and youth and families seem satisfied with the restrictiveness level of services.

Family and provider reports indicate that the greatest challenges for Success for Kids & Families are to identify needs at the system level early in children's lives, to learn how to communicate understanding of culture and its role in helping families, to include informal supports in the form of both people and services, and to clarify the case manager role as one of service coordination rather than case monitoring and family support.

Success for Kids & Families has developed an action plan to address the findings in this study. The program is currently clarifying action steps and responsible staff for program improvement. Training in system of care values and principles has already been provided to staff, and is ongoing. Program administrators also are closely examining program mission, function, and execution to identify those recommendations that may not be currently appropriate or feasible. The interaction of the program and evaluation team has already led to significant program change, as Success for Kids & Families strives to move closer to a program that fully demonstrates system of care values and principles in its daily operations.

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Poster 17

The Price of Collaboration: Predictors of Hours Spent in Collateral Contacts

Presenting: Michael Gordon

Contributing Authors: Kevin Antshel & Lawrence Lewandowski

Introduction

While it has become an article of faith that the delivery of effective mental health care for youth requires a seamless integration of services across the continuum of care, little attention has been paid to the actual cost of those collaborative efforts. We are unaware of any existing research on the average amount of time child clinicians spend on collateral activities or the typical ebb and flow of those activities over the course of treatment. Without hard data, it is challenging for administrators to judge what constitutes a reasonable caseload or how to charge for services in contracts that stipulate coordination of efforts.

The current study presents data from a large number of patients regarding the amount of time clinicians spent in clinical activities outside the context of the billable service. We also wanted to determine whether the collateral ratio can be predicted by demographic variables, child diagnosis, parental psychopathology/family history of mental disorders, and staff variables. We hypothesized that parent factors (such a level of parental psychopathology) would be more predictive than child-related variables.

Method

We amassed data on consecutive referrals over a six-year period to a general child and adolescent psychiatry clinic based in an academic medical center. We only included in this sample children who had been seen for more than the initial intake appointment.

Results

Demographics

The sample consisted of 1639 patients (956 males, 683 females) between the ages of 3 and 17 years, 11 months who were seen for a total of 22,127 appointments (Mean = 13.5 appointments, $SD = 28.8$). Our sample was ethnically and diagnostically diverse, with just over half from Caucasian parents. The others were children of African American, Latino and American Indian heritage.

Seventy percent of the clinic sample was covered by private insurance. Sixty eight percent of the sample received only psychotherapy, while the remaining 32% percent received pharmacotherapy or combined psychotherapy and pharmacotherapy.

The ratio between direct and indirect services

Given a wide range of treatment length, a collateral ratio (total time of appointments / total time of collateral activities) was computed. For every 60 minutes of direct patient contact, 19.7 minutes of collateral activities were performed ($SD = 15.0$).

Predictors of the Collateral Ratio

Sociodemographic variables. Medicaid-funded cases were equal to private and self-pay cases in the ratio of direct-to-indirect effort, $F(2,$

$1636) = 2.11, p = .110$. African American and Latino families had higher collateral ratios than other ethnicities, $F(7, 1631) = 2.08, p = .043$. No gender differences exist in the ratio of direct-to-indirect effort, $F(1, 1637) = 0.57, p = .449$. Likewise, a nonsignificant association between age and collateral activities was detected, $\rho = -.082$. Cases of children with married parents required less collateral activities than those in which the parents were divorced, separated, never married, etc., $F(5, 1632) = 5.17, p = .004$.

Clinical variables. The child's diagnosis (anxiety, mood, disruptive, autism spectrum and adjustment disorders) did not discriminate among the children's collateral ratios, $F(4, 1410) = 0.16, p = .957$. Children who were using / abusing substances ($n = 214$) required more collateral activities than other patients $F(1, 1423) = 5.45, p = .005$. Children with a history of maltreatment / trauma required more collateral activities than those without, $F(1, 1637) = 7.60, p = .005$. No other child clinical variables were associated with the collateral ratio. A maternal diagnosis of depression or anxiety was associated with higher collateral ratios, $F(4, 1411) = 9.16, p = .001$.

Service delivery variables. The collateral ratio was curvilinear and higher in the first and last third phases of treatment, $F(2, 1636) = 6.11, p = .007$. Children who were prescribed medication had a lower collateral ratio, $F(1, 1637) = 14.90, p = .001$. The higher the number of missed appointments, the higher the collateral ratio, $\rho = .463, p = .001$.

Initial clinician ratings of impairment, case acuity. Correlations between initial clinician ratings of impairment and case acuity were all non-significant with Spearman rho correlation coefficients ranging from -0.1 to 0.1.

Conclusions

On average, for every 60 minutes of direct patient contact, a child clinician spends approximately 20 minutes on collateral activities such as meetings, phone calls, and paperwork. That collateral ratio of 3:1 varies depending on the phase of treatment; clinicians spent the most collateral time at the beginning of the case when, presumably, case management is especially important.

As we found in our analyses of factors that predicted the rate of missed appointments (Gordon, Antshel, Seigers, and Lewandowski, 2007), the most powerful predictors of the collateral ratio were related to parent/family variables. Cases that placed the heaviest collateral demands involved mothers with a history of anxiety/depression and families in which the parents were not married. The leading role of maternal depression in this study adds further prominence to this variable as a significant and robust predictor of many aspects of clinical outcome.

Several results were interesting for their lack of predictive power. For example, our data indicated that, contrary to widely held belief, families on Medicaid were no more demanding of collateral contacts than those who paid through insurance. It was also intriguing that the child-centered variables that were significantly predictive of the collateral ratio were not the child's diagnosis, age, or gender, but a history of trauma or substance

use. What we found most sobering is that clinicians' were unable to predict accurately at intake how demanding a case would ultimately be in terms of collateral efforts. According to our data, clinicians should be careful not to jump to conclusions about how time consuming a case will be to manage based on initial impressions.

As for limitations, the logging of collateral hours may have not always been precise because clinicians likely did not log all of their collateral activities. Therefore, the 3:1 ratio may under-represent the number of non-billable to billable hours clinicians spend on cases.

Poster 18

Review of Preschool Antipsychotic Prescribing Prior Authorization Form Formatting and Layout; Considerations for Modification, A Quality Improvement Project

Presenting: Michael Bengtson

The process of prior authorizations for pharmacy management has been in use for many years. In the state of Florida, Medicaid pharmacy management prior authorization allows use of medications not on the preferred drug list. The use of prior authorization in the case of antipsychotic prescribing to preschoolers (children less than six years old) is in place as a tool to manage appropriate prescribing to this vulnerable population. This is in contrast to many prior authorization processes where the primary rationale for implementation may be cost-saving measures.

The preschool antipsychotic prior authorization process has been in place in Florida since May of 2008. This process is initiated with a prescription of an antipsychotic to a child less than six years old who is enrolled in the Medicaid system. The provider completes a form with 28 specific questions, in addition to providing recent clinical notes and an evaluation. Often there are limitations regarding quality of the clinical material secondary to illegibility, thus the value of the form becomes more important. In addition, it is not uncommon that various portions of the prior authorization form are not completed; attempts to review the available clinical material can offset the lost information. The clinical material provided is thus useful but due to the variability in provider documentation practices, it cannot be relied upon as the sole source of information for determination of eligibility for authorization. Additionally, due to the incompleteness of some prior authorization forms and inadequate or illegible clinical information, determination of eligibility may be delayed until the provider can supply an adequate level of documentation.

Inadequate information can lead to either a denial of the prior authorization or a request for more information regarding the clinical circumstances of the patient. Even if a prior authorization is denied, the provider can always resubmit hopefully with the addition of more information of a clinically relevant nature. One of the main difficulties with requesting more information from the provider is the delay of the provision of the medication to the patient.

Consideration of the concerns regarding timely processing and the need for information resulted in focusing on the prior authorization form as an initial target. The process of evaluating the clinical documentation submitted by providers and then attempting to introduce changes would have been overly challenging. In an effort to improve the process, a quality improvement project was initiated to review the prior authorization forms for completeness, as there is some potential to modify this portion of the process.

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The questions on the form were numbered one through 28; these were questions regarding such things as demographics of the patient and the provider in addition to clinical information regarding diagnosis, severity of symptoms, antipsychotic prescribed, alternative treatments attempted, and monitoring. One hundred consecutive forms were reviewed to develop a baseline level of completeness. Each item was scored as answered or blank. At the time of review, attention will be directed to questions that have more or less utility for the determination of eligibility and those that have high and low completion rates. For example, there is high likelihood that the name of the patient and the Medicaid number will be completed and this is administratively necessary. There is potentially a lesser likelihood that the portions of the form regarding monitoring are completed.

Analysis of the data will be based on simple statistics and completion rates of the various questions on the form. Additionally, information regarding the average number of missing responses per form could be determined. Further investigation could yield information regarding the various provider types and completion rates or diagnosis. At this time, no consideration is given to approval or denial of the prior authorization but this could also be investigated as a potential correlation between completeness and approval.

At the time of review, there will be discussion regarding modifications to the current form, to eliminate questions that have lower levels of clinical usefulness and to enhance the likelihood that the more pertinent questions regarding the status of the patient be modified in either the wording or placement on the form to allow for improved levels of completion.

If the review of prior authorization forms completion rates results in a modification of the current form, then at some future date a similar review of the completion of the form should be undertaken to determine if the modifications made were of value. The use of forms to document clinical features of patients such as diagnosis is less complicated than trying to document current levels of symptoms impairment. There is inherent potential for diminished communication of information as the information gets more removed from the clinical setting. Attempts should be made to make the process of prior authorization as foolproof and timely as possible. There are advantages to a quality process for the persons involved in the evaluation, the providers and most of all for the patients. The focus of the quality improvement review project is to enhance the likelihood that there is appropriate prescribing of antipsychotics to children less than six years old.

Poster 19

The Impact of a Learning Collaborative upon Child Mental Health Service Use

Presenting: Mary Cavaleri & Geetha Gopalan

Contributing: Mary McKay, Taiwana Messam, Evelyn Velez & Laura Elwyn

Introduction

The purpose of this presentation is to investigate the effectiveness of a learning collaborative upon use of child mental health services. Although up to one-fourth of youth could benefit from treatment, most either never engage in services or terminate prematurely.¹⁻² As a case in point, community based mental health programs often report that “no-show” rates for intake appointments exceed 50%.³ Studies indicate that engagement interventions implemented during initial contacts with youth and families can boost service use substantially⁴⁻⁵, however, there is little guidance regarding how agencies can assist families in becoming involved in services. Accordingly, a learning collaborative was conducted to improve mental health service use through training agencies in administering intensive engagement strategies.

Methodology

In November, 2005, the Westchester Department of Mental Health and Mount Sinai School of Medicine formed a learning collaborative. Nine state-licensed agencies were invited to submit an application to participate, and eight agencies participated in the collaborative. Complete data were collected from five agencies. Two to five staff per agency formed teams and participated in three learning sessions where they were trained in two evidence based engagement strategies developed by Dr. Mary McKay⁶⁻⁷, the facilitator of the collaborative. Between learning sessions, teams tested and studied the effects of the intervention at their agencies. Each agency focused on and submitted data pertaining to: (a) show-rates for first intake appointment regarding all new evaluations of children and adolescents between November - December 2005 and October - November 2006, and/or; (b) attendance at any scheduled clinic appointments subsequent to the first kept intake appointment for all new evaluations from April through November, 2006.

Findings

Two agencies (Agencies 2 and 5), which focused on improving initial engagement of clients (with one of which focusing on both outcomes) showed an improvement in client engagement. More specifically, at baseline, Agency 2 reported that 75% of intakes scheduled were kept. At the last time point, this had increased to 85.2% and for October - November 2006, a time period reasonably comparable to the baseline in length and seasonality, 90.8% of scheduled intakes were kept, a 21% increase over the previous year. Agency 5 reported an engagement rate of 74.3% at baseline. At the last time point, this had increased to 83.1%. For the October - November 2006 period they reported an engagement rate of 78.1%, a 5% increase over the baseline period in the previous year.

Agencies 5, 1, and 3 focused on improving their retention rates. At baseline, the retention rate or percentage of sessions scheduled that were kept was 68.1% for Agency 5, whereas by November 2006 this rate had increased to 74.7%. The rate for the October - November 2006 period was also 74.7%, reflecting a 10% increase over the baseline period in the previous year.

Agency 1 focused entirely on improving their retention rate. At baseline, their rate of sessions kept out of sessions scheduled was 74.8%, but by November 2006 this increased to 85.4%. In the October - November 2006 period this rate was 86.8%, representing a 16% increase in retention rate over baseline. Agency 3 also focused on improving its rate of retention.

In November - December 2005, their rate of sessions kept to sessions scheduled was 82% and this increased to 87% in November 2006. Their retention rate for the October - November 2006 period was 83.5%, reflecting a modest increase of 2% over the baseline rate.

Finally, Agency 4, which did not implement any of the engagement strategies and thus acted as a form of control, showed a decrease in both engagement rate and retention rate. At baseline, their engagement rate was 89.8% and at Time 8 had decreased to 81.5%. Their engagement rate for the October - November 2006 period was 81.7%, reflecting a 9% decrease from the November - December 2005 period. Similarly, their retention rate at baseline was 74.6% and decreased to 65.7% at Time 8. For the October - November 2006 period their retention rate was 64.7%, a 13% drop from November - December 2005 period.

Conclusion

The results of this learning collaborative add support to the growing literature which suggests that multi-agency consortiums can effectively improve service use among youth with mental health difficulties and their families⁸. As evidenced by the findings, the two agencies which focused upon increasing initial service use showed that more youth were being engaged in their services comparative to a year ago. Moreover, the three agencies which focused upon improving retention rates evidenced an increase in kept subsequent appointments. These findings end to the success of the learning collaborative especially when compared to Agency 4, which did not implement any of the engagement strategies, and evidenced a decrease in both engagement and retention rates from baseline.

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Poster 20

Using Data to Inform Decision-Making in Kansas Children's Community-Based Services

Presenting: Stephen Kapp & Karen Stipp

Introduction

Providers of community mental health services handle multiple streams of data including computerized program evaluation outcomes, but often lack resources for evaluations that inform local decision-making. There were barriers to evaluation before the advent of computerized evaluations, and barriers are ongoing even with current computer capabilities that generate an abundance of data. This study is useful to mental health practitioners who self-evaluate, and to program evaluators who would support local decision-making.

The University of Kansas, School of Social Welfare developed an automated information management system (AIMS) for collecting and disseminating mental health outcomes to state and federal stakeholders. The state mental health authority recognized the importance of informing local service delivery decisions, and to that end, suggested that AIMS inform not only external stakeholders, but also local quality improvement efforts.

Preliminary interviews with children's community-based services (CBS) directors indicated that there is limited connection between AIMS and local decision-makers. Literature from both social service and business sectors indicates that such a gap between data and the knowledge that informs local decision-making is common (Drucker, 1988; Patton, 1997).

Researchers wondered, if not AIMS, then what? Defining data as whatever feedback, outcomes, or information CBS directors use to draw conclusions and make decisions, researchers sought to discover (1) how CBS directors access the data they use; (2) what resources are requisite to data utilization; and (3) how it might be possible for AIMS to find local applications.

Methodology

This study explored mental health service delivery processes, in the qualitative tradition which has proven useful in mental health professions including rehabilitation, psychiatry, psychology, and social work, for studying "the point of contact between provider and client" (Luchins, 2003, p. 185). Researchers initiated the study by conducting a preliminary interview, either face-to-face or by telephone, with four Kansas CBS directors. Participants indicated that they looked at quarterly AIMS reports of aggregated data, but did not use them for clinical or programmatic decisions. Participants further indicated that they did not use data, but follow-up interviews were conducted based on prior studies indicating that large-scale program evaluations eclipse mental health practitioners' perceptions of their own data utilization (Drisko, 2001; Elks & Kirkhart, 1993). In prior studies, practitioners stated they did not use data, yet demonstrated "constantly evaluating their practices using empirical data" (Drisko, p. 423).

Kansas community mental health is partitioned into 27 catchment areas, each of which includes CBS. Interviews with 25 of the 27 CBS directors generated the data for this study. Researchers developed the interview questions from the literature review and from the preliminary interviews. Eleven participants answered interview questions via telephone and 14 via a web-based survey tool.

Researchers analyzed directors' survey responses through close reading and rereading, coding, and the development of themes, for a comparative analysis within and between texts. Interview questions defined the first code level. Open coding that captured the breadth of directors' approaches to knowledge building informed the second code level; uniqueness and commonality of director responses informed the third code level (Boeije, 2002; Drisko, 2001). Researchers consulted for inter-rater agreement.

The research team reported initial findings at a CBS directors' meeting, where attendee agreement with the findings provided an assurance of study trustworthiness. Subsequent expanded interviews with 12 participants in the larger study expanded and authenticated the study's preliminary findings.

Findings

CBS directors' offices are full of data. Directors see state hospital admission and discharge data, consumer satisfaction surveys, psychiatric residential treatment facility screenings, managed care access data, service hours, and quarterly AIMS quarterly reports. Directors receive face-to-face feedback from parents, youth, and referral sources, and information housed in client charts. CBS directors manage available data to evaluate program effectiveness and measure staff performance.

AIMS is a data management tool that is invaluable for collecting, aggregating, and disseminating information for state and federal reporting. AIMS is less valuable for informing local decision-making. Quarterly AIMS reports sometimes provide locally useful information, but participants in this study indicated that their local evaluations require team-specific, client-specific, and timeframe-specific information. The bulk of CBS data-devoted resources are applied to gathering and inputting AIMS data, but directors experience little cost benefit from their aggregated data.

Many directors find existing data inadequate for their needs, despite its volume. When additional resources are available, directors generate local surveys with questions about program effectiveness and client progress. Directors generate standardized measures developed around best practice literature to suggest treatment and program decisions.

Conclusion

CBS directors actively measure and evaluate local outcomes, and are supported in their efforts by organizational supports for data utilization. Study recommendations include: (1) Access to business intelligence software, which makes it possible to manage multiple streams of data; (2) Access to best practices and data-devoted staff, for generating client outcome measures that suggest appropriate treatment and program responses; and (3) Web-based business intelligence, which makes it possible access and use AIMS data housed outside the CBS.

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Poster 21

Support Services and Child Outcomes among Children Served in a Systems-of-Care Program

Presenting: Melissa Azur & Lucas Godoy Garazza

Introduction

Systems of care (SOC) have become a model approach to the delivery of mental health services for children with serious emotional disturbances. A key principal of a SOC is that children receive comprehensive services that are guided by the individual needs of the child and family. These services may include “traditional” mental health services such as outpatient therapy and psychopharmacology, but may also include services such as recreational activities, transportation services, and family support services. While these services are believed to enhance a child and family’s ability to cope, function, and progress toward recovery from mental health problems, little is known about which children receive these types of services and how their outcomes vary from children who do not receive support services. This study addresses this gap in the literature and (1) examines the characteristics of children who receive recreational and after school services, child support services, and family support services, and then (2) examines the association between each type of support service and internalizing and externalizing problems among children receiving services in a federally funded systems of care program. To that end, a mixed or hierarchical model was used to address the research questions. Mixed models appropriately take into account not only the nature of longitudinal data but also account for additional levels of clustering, such as system of care program sites.

Method

Data

The data are from children and families who participated in the national evaluation longitudinal outcomes study of the Children’s Mental Health Initiative. Data were collected at intake into services and at six month intervals for 36 months.

Sample

Children ($n = 2763$) between 5-17 years who enrolled into services between 1998-2005 and who had complete data in at least one time point were included in the study sample. The presented results are based on a random subsample ($n = 1363$) of these children; this sample was selected for model formulation purposes. There were on average 2.6 observations (i.e., follow-up data) per child.

Measures

Behavior Problems: Internalizing and externalizing problems were measured with the Child Behavior Checklist (CVCL; Achenbach, 1991). The CBCL is a reliable and valid instrument that assesses caregiver perception of child behavioral and emotional problems. Standardized broad band scores of internalizing and externalizing syndromes were used in the present study.

Service Use: Information on child and family services was obtained from caregiver report. That information was used to create three support service categories: recreation and after-school activities, child support services (includes behavioral/therapeutic aide, family preservation, day treatment, independent living services, and physical health services, e.g., vision assessment, physical therapy, audiology, etc.), and family support services (includes family support, transportation services, respite care, and flexible funds, e.g., subsidized child care, clothes, toys, etc.).

Covariates: Child’s age, race/ethnicity, gender, source of referral into services, family household income, and lifetime history of psychiatric hospitalization were obtained from caregiver report.

Analysis

The analyses were conducted in two steps. In the first step, 3 multilevel logit models were fit to estimate the probability of receipt of each type of support service as a function of the covariates, length of time in the study, and total behavior problems in the previous measurement wave. In the second step, internalizing and externalizing behaviors, in turn, were modeled as a function of the type of support service received, again using multilevel modeling and adjusting for the covariates. Both models included child specific and grantee specific random effects.

Findings

The probability of receiving recreation services, child support services, and family support services decreased over time in the study. Relative to Caucasian children, African American children were more likely to receive recreational services and Hispanic children were less likely to receive child support services. Age, gender, and race were unrelated to receipt of family support services.

Children’s internalizing and externalizing problems improved, at a decelerating pace, over time in the study. Children who received recreational services entered into the system of care program with fewer internalizing and externalizing problems than children who did not receive recreational services. They also improved at slower rates. There were no significant differences in either internalizing or externalizing problems among children receiving child support services or family support services, compared to children who did not receive those services.

Conclusion

Mixed models offer an appealing method for analyzing longitudinal data that takes into account the clustering of data and maximize the information available in the dataset. The study found that support services are an important part of the array of services available to children and their families in a system of care. As children progress through treatment, they are less likely to receive support services. Given that children’s behavior problems improve throughout treatment, this finding may suggest a decreasing need for these ancillary services. The lack of significant differences in improvement in behavior problems for children who received child or family support services could suggest that systems of care programs appropriately provide services to fit the needs of children and their families. Further research is needed to better understand how children are identified to receive supportive services and how supportive services affect the health and wellbeing of children with serious emotional disturbances and their families. Mixed methods are a valuable tool in analyzing complex data and can be used to extend this research and address similar research questions.

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Poster 22

Culturally Competent Systems of Care in the 21st Century: Challenges of the 20th and 21st Century

Presenting: Betty Blackmon & Deborah Purce

Introduction

Child welfare agencies are essential participants in many systems of care, and in a number of circumstances both systems serve the same populations. The promotion of interagency collaboration between them is a laudable goal that demands a more focused strategy to address the reduction of disparities that exist within child welfare and mental health agencies that serve children of color and their families. Reducing the disparities that continue to exist within these two systems is the challenge of the 21st century.

This challenge requires research into the barriers that have thwarted efforts to achieve cultural and linguistically competent services for this population. Meeting this challenge requires an examination of current and past efforts as well as progress directed toward implementing one of the core values of the systems of care philosophy: cultural and linguistic competency (Stroul & Friedman, 1996). There is a general consensus that the culturally competent services provided within the systems of care will provide children with much needed, high quality mental health services and that the capacity to deliver these services across child-serving agencies will move from being part of the vision of systems of care to positive outcomes.

Problem

Over the last three decades the mental health and social services systems have been challenged to address cultural competence in service delivery and to recognize that children of color and their families do not necessarily receive services that are appropriate to meet their culture-based needs. Although most child-serving systems strive to reduce the disparities that exist within mental health and social service delivery systems through culturally and linguistically appropriate services, the need to close the gap between vision and outcomes is essential.

According to the National Action Agenda (USDHHS, 2000), some child-serving systems have implemented culturally competent systems of care; however, other systems have not implemented measurable, culturally and linguistically appropriate services. The lack of culturally competent services raises a variety of research questions (USDHHS, 2000). This poster presentation will provide presenters and participants an opportunity to engage in dialogue regarding questions that remain unanswered about the delivery of culturally competent services at all levels of the system of care in the 21st century.

Research questions

- How do we resolve the incongruence between the goal of establishing culturally competent systems of care that provide appropriate services

to diverse population with the reality that very few child-serving systems are culturally competent?

- Does the failure to achieve cultural competency within systems of care result in child welfare and mental health care disparities for children and families of color?
- How will we know when we have achieved cultural competency?

Methodology

A review of secondary data from the U.S. Department of Health and Human provided information about the delivery of mental health services to diverse populations. An analysis of these reports included comparisons of data over the span of a decade. A second part of the process was to review the literature studying organizational and mental health cultural competence. The literature review included over twenty years of published research to determine what is known and written about organizational competency principles, values, effectiveness, and their impact upon service delivery outcomes.

Findings

Some literature questioned the fields' ability to measure the effectiveness of implementation and whether a culturally competent system will lead to a of disparities within child-serving agencies such as state child welfare institutions and mental health providers. This literature is replete with concerns about the proposed goals and principles of culturally competent systems of care versus the reality of operationalizing them, and calls for organizations to make the goal a reality. However, organizations question whether they are able to implement the principles and values of a culturally appropriate system that includes measurable indicators of achievement. For example, publications from the U.S. Department of Health and Human Services suggest that the child welfare system does not meet culturally competent standards of care.

Conclusion

It appears that there is still ambivalence about the ability to define and establish culturally competent standards of care, to implement them, and to measure their outcomes.

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Poster 23

¡ADELANTE! Advancing a Network's Cultural Proficiency...aka "It doesn't take a Rocket Scientist to Build a Culturally Competent System of Care"

Presenting: Malena Albo, Matt M. Miller & Bonni D. Hopkins

How do we respond rapidly to changing demographics (age, cultural, linguistic etc. . .) in developing, maintaining and expanding our services and delivery systems to effectively meet emerging needs? This presentation will address the challenges to existing paradigms on working with diverse populations, and depict how concrete resources and tools can be used to create dynamic services and systems tailored for individual

communities of color, ages, etc.. An overview of cultural tenets will serve as the foundation for effective techniques to engage participants from a wide range of cultural backgrounds. Information on multicultural issues in mental health promotion programs, including potential future trends, will be provided, along with an overview of specific, proven techniques for engaging a diverse population in mental health promotion programs, including engaging Latino youth in behavioral health care.

Poster 24

Using Data Analysis to Improve System of Care Services for American Indians

Presenting: Daniel Dickerson & Carrie Johnson

Introduction

Psychiatric and substance disorders have been recognized as significant problems among American Indian/Alaska Native (AI/AN) youth (Dixon et al., 2007). For example, in a study conducted among Northern Plains youth, higher rates of attention deficit–hyperactivity disorder, and conduct and oppositional defiant disorder were found among Northern Plains AI/AN youth than non-Native youth (Beals et al., 1997). AI/ANs are also especially likely to experience a range of violent and traumatic events involving serious injury or threat of injury to self or to witness such threat or injury to others (Manson et al., 2005), which may increase the odds of psychiatric and substance use disorders among this population. With regard to substance abuse, AI/AN youth experience significantly higher rates of alcohol and illicit drug use, have an earlier onset of use, and experience more severe consequences of drug use compared to any other ethnic/racial group in the United States (Dixon et al., 2007).

Two-thirds of AI/ANs reside in urban areas. However, studies analyzing psychiatric and substance use characteristics among urban AI/AN youth are limited. Thus, further studies are needed in order to increase our understanding of psychiatric disorders and substance use risk factors among urban AI/AN youth; such studies may then assist in improving prevention programs and developing culturally-tailored interventions.

Methodology

Participants

A total of 118 AI/AN youth receiving psychiatric services at an urban clinic are included in this study. Males comprise 57.6% of the sample. The average age is 9.6 years. Seventy-one (60.1%) are 0–11 years of age, 46 (39.1%) are age 12–18 years of age, and one (0.9%) is 19–21 years of age.

Source of Data

This study analyzes baseline descriptive data retrieved at an urban clinic program providing mental health care to urban AI/AN youth in the Western United States. Data analyzed were retrieved from the national evaluation of the Center for Mental Health Services' (CMHS)-grantee program at this clinic.

Assessments

Enrollment and Demographic Information Form (EDIF): The EDIF gathers demographic, diagnostic, and system of care enrollment information on all children receiving funded system of care services.

Substance Use Survey–Revised (SUS–R): The SUS–R gathers information on youth's use of alcohol, tobacco, and other drugs including types of substances used and frequency of use.

Caregiver Information Questionnaire–Intake (CIQ–I): The CIQ–I is administered to caregivers and gathers additional demographic information, as well as information on risk factors, family composition, custody status, service use history, and presenting problem(s) for children.

Youth Information Questionnaire–Intake (YIQ–I): The YIQ–I is a youth version of the CIQ–I. It is administered to youth 11 years and older.

Child Behavioral Checklist (CBCL 6–18): The CBCL 6–18 is administered to caregivers and measures behavioral and emotional problems in children ages 6–18. The CBCL 6–18 produces eight narrow-band syndrome scores: anxious/depressed, withdrawn/depressed, somatic complaints, social problems, thought problems, attention problems, rule-breaking behavior, and aggressive behavior. The CBCL-6–18 includes two broadband syndrome scores for internalizing and externalizing behavior and a total problem score.

Findings

Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) Axis I diagnoses were analyzed with regard to psychiatric disorders. Mood disorders (41.5%) and adjustment disorder (35.4%) were the most frequently reported diagnoses in this sample of children and adolescents, followed by posttraumatic stress disorder and acute stress disorder (23.1%). With regard to substance use, alcohol use was commonly reported (69.2%), followed by marijuana use (50.0%).

With regard to psychosocial characteristics, witnessing domestic violence was most commonly reported (84.2%); followed by living with someone who had a substance abuse problem (64.7%); living with someone who was depressed (55.6%); living with someone who was convicted of a crime (47.4%); living with someone who had a mental illness, other than depression (29.4%), and; being physically abused (26.3%).

Furthermore, the majority of patients (over 55%) demonstrated rule-breaking behavior; had problems with attention and/or aggression, had somatic complaints, felt withdrawn, and experienced social problems and/or thought problems.

Conclusion

Findings from this descriptive study revealed high rates of mood and adjustment disorders in addition to high rates of alcohol and marijuana use among a sample of urban AI/AN youth. High rates of physical abuse and exposure to significant psychosocial stressors (including living with family members with psychiatric and substance use disorders and criminal histories) may be risk factors for depression, adjustment disorders, and post-traumatic stress disorder among urban AI/ANs. Additionally, various reports suggest that intergenerational, historically-based trauma experienced by AI/ANs throughout U.S. history may serve as a foundation for many social problems experienced in this population.

Results obtained from this study have offered mental health administrators and providers the opportunity to enhance culturally-relevant treatment strategies for this population. For example, a series of trainings have been provided to clinicians regarding substance abuse screening and brief interventions. Also, individualized treatment plans for AI/AN youth with comorbid psychiatric and substance use disorders have been implemented. In addition, addressing the need for family involvement and culture-based interventions have been emphasized. For example, cultural activities including drumming, bead making workshops, and equine-assisted therapy are now provided. As a result, we believe treatment outcomes may be enhanced in addition to a heightened sense of cultural identity. In addition to these treatment recommendations, the authors recommend further research analyzing the relationship between psychiatric and substance use disorders among urban AI/ANs.

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Poster 25

Assessing Consumer-Driven and Culturally-Competent Care

Presenting: David Saarnio & Valencia Cash

Introduction

“Consumer-driven” and “Culturally-competent” are critical elements of mental-health services to families. For example, the Substance Abuse and Mental Health Services Administration (SAMHSA) states in its Cultural Competence Standards in Managed Care Mental Health Services (<http://mentalhealth.samhsa.gov/publications/allpubs/SMA00-3457/ch1.asp>) that “a consumer-driven system of care promotes consumer and family as the most important participants in the service-providing process.” Similarly SAMHSA states that a culturally competent approach includes “attaining the knowledge, skills, and attitudes to enable administrators and practitioners within systems of care to provide effective care for diverse populations, i.e., to work within the person’s values and reality conditions” and “acknowledg[ing] and incorporat[ing] variance in normative acceptable behaviors, beliefs, and values in determining an individual’s mental wellness/illness, and incorporating those variables into assessment and treatment.”

The present study represents a preliminary attempt to capture the ongoing cultural competence of service providers in the Delta region of Arkansas, where racial and socio-economic intolerance have been common. The purpose of the present study was to examine whether families are experiencing consumer driven and culturally competent care by child-serving agencies, including a regional system of care. In particular, for the present poster, four questions were examined: (1) do caregivers believe they are respected by agency personnel, (2) are the services that are provided consumer driven, (3) are families included in the development of services, and (4) are service providers attempting to understand the cultural beliefs and values of families?

Method

A university center and a family organization jointly developed an assessment instrument and trained cultural brokers to interview families in four Arkansas Delta counties. Cultural Brokers (individuals within local communities) were used to ensure that the interviews were tailored to the specific culture of each community.

The interviews assessed the degree to which caregivers believed that family-based and culturally competent practices exist among four child-serving agencies: mental health, juvenile justice, schools, and child welfare (participants reported on the individual from the service agency with whom they interact the most when receiving services for their child’s care, not on all agencies). Of the 200 caregivers in the study, the majority were African American (about 75%), 16% percent identified themselves as White, and 7% said they were Hispanic. Forty percent of participants evaluated service providers from mental health, and 30% of caregivers evaluated service providers from school-based services. The remaining participants were from juvenile justice and child welfare. Because reading difficulties are a common issue in the Delta region of Arkansas, interviews were used, rather than traditional pen-and-paper surveys.

The interview was composed of 18 questions such as “my child’s [child-serving agency representative] understands how I see my child’s problems” and “my child’s [child-serving agency representative] respects our family’s values and customs.” Responses to all questions were limited to three options: Never, Sometimes, and Most of the Time. In addition, a follow-up question was used for each item (e.g., “explain,” “in what ways,” “how have they...”). All interviews were conducted face-to-face,

and all forms (including consent for participation in the study) were read to the participants. The interviews took approximately thirty minutes to complete. Cultural brokers were compensated for their work and families received a gift card from Wal-Mart.

Results and Discussion

The present research focuses on the four questions introduced above. Sample items and results addressing each of the 4 questions are presented here. The entire survey will be included in the actual presentation, along with qualitative follow-up responses.

First, based on anecdotal accounts, respect for families and the caregiver is more common than might have been anticipated. 91% of respondents said they felt respected most of the time, and 86% said their families’ values and customs were respected most of the time.

The second question addressed if respect translates into a consumer-driven interaction. About 75% said the service provider “helps us get the services that we need,” and 80% said the provider is “really helpful.” Although clearly most providers are doing well, both of these numbers are lower than those for respect.

Third, caregivers often view the care as consumer-driven, but a meaningful minority do not. For example, about 75% of families said that they are included in decisions about their child’s care most of the time, and that they are accepted as important members of the team helping their child.

Fourth, when focused on cultural beliefs and values, only about 66% of providers appear to consider the families’ background when selecting treatment materials (“most of the time”), and only about 50% bother to take time to learn about the culture of the family (33% of caregivers report that providers never take the time).

The current descriptive findings reveal several noteworthy patterns. The caregivers found their agency service representatives respectful and helpful, suggesting that agency representatives have embraced at least some tenets of consumer driven care. However, family as a partner in the care process is not yet universal. Additionally, the cultural competence component of care appears to be clearly lacking. For service providers “to work within the person’s values and reality conditions” as suggested by SAMHSA, they must first understand the cultural background of families. About 50% do not even attempt to do so. Interestingly, further analysis indicated that there are pockets of cultural competence even within the region examined here. For example, a county-by-county analysis showed that in one county 62% of participants said child serving providers NEVER took time to learn about their culture, whereas that number in another county was only 12%.

Because of the limited geographical and demographic focus, generalizations from these data are clearly limited by the population. However, there are at least four discussion points to be provided in this presentation: (1) consumer-driven care and cultural competence have many assessable facets; (2) cultural understanding is the weakest component in this sample, and may reflect a problem in other populations; (3) there are positive elements of family-provider relations that can be built upon to enhance culturally competent services; and, (4) targeted analysis can provide a basis to focus limited resources to enhance culturally competent care.

Poster 26

Developing a Culturally Responsive Assessment Tool for Native American Youth

Presenting: Pauline Jivanjee, Barbara Friesen, Kathleen Fox & Cori Matthew

Introduction

A major challenge for culturally specific organizations in an EBP policy environment is to establish evidence of the effectiveness of services. In this project, a collaborative research team has developed a culturally responsive assessment tool for Native youth that is grounded in research findings and positive youth development and resilience theories. This poster presentation describes a participatory research project for building practice-based evidence within culturally-based programs. The poster will describe the development and testing of the NAYA Assessment Tool (NAT), a culturally responsive tool for assessing Native American/Alaska Native (AI/AN) youth. Partners in this project are three organizations based in Portland, Oregon, the NAYA Youth and Family Center, a culturally specific direct service non-profit youth development organization, the National Indian Child Welfare Association (NICWA), and the Research and Training Center on Family Support and Children's Mental Health (RTC). Each of the partners brings a unique set of resources, skills and perspectives to the project.

Methodology

Phase I. The research partners conducted focus groups with key stakeholder groups to identify desired outcomes for Native youth. Informants included middle and high school, and foster youth, parents, elders, NAYA board members and community partners; and NAYA staff and program managers. Participants responded to six questions focused on definitions of youth success, and challenges and supports for Native youth success. Notes from the groups were analyzed using the four areas of the Relational World View (RVW) Model (Cross, 1995) as a framework for identifying themes. Focus group responses that addressed the question, "What is 'success' for Native American youth?" were a focus of analysis.

Phase II. In this phase, the team identified two to four outcomes in each of the areas of mind, body, spirit, and context that were seen as essential to an assessment and individualized case planning tool. The research team conducted literature reviews and used information from personal contacts to identify research instruments with good psychometric properties that reflected the targeted outcomes for possible inclusion in the new tool. The team reviewed many instruments and weighed the dilemmas associated with the desire to use well-established instruments while aiming to minimize burden on youth participants.

Throughout this process the team consulted with NAYA staff to gain their recommendations about age-appropriate and culturally sensitive language. Where we could not find existing instruments, we developed questions that addressed issues such as youths' living situations, financial well-being, and sense of safety.

The team presented a preliminary draft of the on-line tool to the NAYA staff, who gave valuable feedback on the content and language of the items. A particular focus of discussion was a list of culturally appropriate activities that had been developed with Mid-West tribal communities and NAYA staff recommended the development of a list of cultural activities more commonly practiced by Northwest Indians. Our NICWA collaborator played a particularly important role by facilitating a discussion with elders of the NAYA community in which they identified appropriate cultural activities to add to the list.

The next step involved a review of the assessment instrument, which had been named the NAYA Assessment Tool (NAT), by NAYA youth. NAYA staff arranged for two groups of middle school and high school youth to participate in a pre-pilot test and group discussion of the NAT. Twenty youth completed the NAT online, and all except one completed it in under 20 minutes. Youth provided feedback on the content of questions, the clarity of wording of the items, and the age-and cultural-appropriateness of questions.

Parallel research team activities have focused on linking outcomes assessed by the NAT with research literature, for example, cultural identity was mentioned as a key outcome for Native youth. In the literature, positive cultural identity of Native youth has been associated with reduced prevalence of suicide, school success, reported increased school belongingness, stronger adherence to anti-drug norms and higher self-esteem.

Findings

Youth recommendations from the pre-pilot test of the NAT were to add explicit response choices. For example, in response to questions about whether youth are interested in joining specific youth-oriented activities, they recommended the addition of a "not interested" option, as well as an "interested" option. Pre-pilot participants also recommended increasing cultural sensitivity by using the phrase "choose to live by" in place of "live by" with reference to Native cultures or other cultures. They encouraged age appropriateness by suggesting including a question about "have you ever used..." before questions about the use of alcohol and drugs. Finally, youth participants recommended that the language in some questions be updated, for example, they suggested the phrase "down in the dumps" be changed to "mild depression."

Conclusion

Findings from the focus groups, literature reviews, NAYA staff feedback, and pre-pilot test have provided a foundation for the development of a culturally appropriate assessment and individualized service planning tool for Native youth. This will be valuable in the development of practice based evidence with Native youth. Current work at NAYA is focused on the integration of evaluation into the organizational culture. Working with NAYA staff, the team has also identified 23 cross-functional interventions that are commonly used at NAYA which will be the focus of evaluation activities using the NAT.

The development of an assessment and planning tool with measurable outcomes across programs will be the basis for tracking the progress of individual youth served by NAYA, and the data can also be aggregated for program evaluation purposes. By creating one instrument that can be used in practice as well as to establish practice based evidence, evaluation efforts can become more organic in the organization. This project demonstrates the value of collaboration between researchers and direct service providers in establishing the effectiveness of programs.

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Poster 27

Creciendo Unidos/Creating Alternatives: An Overview of a Cross Generational Community Driven Practice

Presenting: Emilio Vaca

Introduction

The need for more empirical evidence to build the knowledge base of effective models for Latino Families in the areas of health and wellness, prevention and early intervention, strength based and culturally relevant practice, building resiliency, enhancing community leadership and fostering civic engagement, and increased positive mental health outcomes for families is apparent. School related risk factors such as high school drop outs, teenage pregnancy, habitual truants, discipline referrals, suspensions, and overall risk for academic failure call attention to an urgent need for a deeper understanding about the underlying factors that influence these behaviors. The *Creciendo Unidos/Creating Alternatives* community driven model has the potential to increase levels of school involvement and motivation for achievement for Latino youth, and enhance relationships between families, especially for English language learners, working towards the goal of decreasing the achievement gap and addressing disproportional Latino representation in the both the child welfare and the juvenile justice systems.

Evolution of a Community Driven Practice

In 2005, 6 families that consisted of 7 parents and 4 youth began to meet as an informal group once a week. *Creciendo Unidos/Creating Alternatives* organized around the vital need to address the concerns the families had around raising their children. Contributing risk factors for youth in the community of Kings Beach includes structural racism such as immigration status, cultural competency, lack of affordable activities, transportation, and quality child care. Other areas involve language barriers and high rates of poverty.

Two primary concerns of the youth and family members were the spread abuse of "Meth" as well as the risk of gang involvement and gang related criminal behavior. Latinos have been identified as a high risk group for depression, anxiety, chemical use and dependency (Rios-Ellis, 2005). Latinos also experience disproportionate rates of mental health and substance abuse disorders and are more likely to underutilize mental health services. Despite this, the families who started *Creciendo Unidos/Creating Alternatives* were frustrated because they had repeatedly attempted to access help for their children and had either been "turned away" due illegal immigration status or not meeting the "criteria" required for services. For the families involved in *Creciendo Unidos/Creating Alternatives* Kings Beach, California, it was extremely evident that the dominant culture's way of defining and solving problems were failing them and that they needed to find new ways to bring to light the issues they were facing.

While the original membership of *Creciendo Unidos* was an intergenerational group made up of parents and their children, eventually a separate youth led sub group formed, calling themselves *Creating Alternatives*. They met parallel to the parent group, designed activities and examined issues that were relevant from the perspective of first generation children from Mexico. They defined their own agenda through their own experiential lens, one key determinant for them was how the rate at which they were acculturating influenced their behaviors, emotions, and attitudes. This, in contrast to the rate at which parents were acculturating sometimes caused significant stress in the home. By giving voice and empowerment to the youth themselves, they were able to focus on resolving conflicts that arose from living in two worlds, that of the dominant culture and also that of their traditional family.

The emergence of *Creciendo Unidos/Creating Alternatives* is the how a small group of families in Kings Beach responded to a variety of stressors placed on them as immigrant families. Through community organization, family-driven action, and youth voice, *Creciendo Unidos/Creating Alternatives* developed culturally relevant and creative solutions. An important mechanism emerged for families to address the highly complex problems that their children were facing. The entire process unfolded in the living rooms and kitchen tables of the families themselves, independent from criterion set forth by the formalized institutional model. *Creciendo Unidos/Creating Alternatives* continues to yield positive results as determined by community consensus over time, measured by community embrace, and acceptance. Qualitative data in the form of narrative and interviews conducted for the Anti Meth DVD showcase the impact of the program in the community.

Essential Elements

This community driven practice is an ideal model of what it looks like in a community where people actively worked together to accomplish what they recognized as a mutual concern. Lacking a formal process, the style of leadership is what sets this process apart from the typical evidenced based practice model. What makes this distinct is that while families see the whole picture, and they define goals and objectives through their own culturally relevant value systems. Atypical forms of power and authority showcase the importance of informal power based on interpersonal relations rather than contractual arrangements, and all decisions are made for the benefit of the collective rather than the individual. Members of this group are distinctively interdependent upon one another, and the relationship building is the primary driver of the process. One key underlying assumption is that the way you understand your partners at the table takes precedence over what you expect them to produce or deliver, so it is not an outcomes based process that is measured by task accomplishment. This naturally flowing process developed organically and was directed by community members exclusively, and reflects a process that is not based on hierarchical power structures.

As a result of this cross-generational approach the groups have been successful in producing results with a Community/Youth Led Anti-Meth DVD which has been featured to the California Governors Prevention Advisor Council, and distributed to all California Friday Night Live Partnership Chapters which are in all 58 counties. In respects to empowerment and civic engagement the groups hosted, organized and created a Community/Youth Empowerment Conference (first ever in Lake Tahoe) with over 70 youth participating discussing real youth issues and developing action plans to address those concerns. As a result of the conference the youth have organized a high school group that includes various members from different youth organizations into one that is focusing on creating cultural events, promote education, development of a scholarship, and fostering community service.

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Poster 28

Creating Trauma Informed Care Environments: A Learning Collaborative for Youth Residential Treatment

Presenting: Victoria Hummer, Norin Dollard & Fran Myers-Routt

Introduction

The Florida Trauma Informed Care Learning Collaborative (FTIC-LC) is focused on the implementation of standard trauma-informed care practices in residential treatment environments for children, youth and their families. The project is one of several statewide strategies addressing trauma and recovery, including: (a) reducing the need for seclusion and restraint in residential treatment settings, (b) disaster response, (c) crisis Intervention training for law enforcement officers, (d) infant mental health, technical assistance to providers, (e) interagency agreements among those serving trauma survivors, and (f) the implementation of trauma-informed care across multiple service sectors. Trauma-informed care is a comprehensive approach that includes prevention, supports trauma-specific intervention, infuses knowledge and behaviors into all aspects of organizational operation, and includes identification of agency resources and assets to support the needed organizational cultural shifts toward successfully implementation. The FTIC Learning Collaborative is a project of the Louis de la Parte Florida Mental Health Institute at the University of South Florida.

The FTIC-LC project began as a sub-study of a larger out-of-home care study funded by the Agency for Health Care Administration (ACHA) in Florida. The Department of Children and Families, Division of Children's Mental Health, was instrumental in the development of practice standards and promotion of the project. The project has also "stolen shamelessly" (part of the learning collaborative process) from the National Child Traumatic Stress Network (NCTSN) which provided the overall Learning Collaborative framework and materials, and technical assistance.

The initial trauma-informed care study focused on Medicaid funded residential treatment settings including the following: Statewide Inpatient Psychiatric Programs (SIPP), Specialized Therapeutic Foster Care (STFC) and Therapeutic Group Care Services (TGC). The study identified Florida provider agencies already using trauma-informed approaches and addressed whether and how organizational culture supports trauma-informed practices. This process informed a set of field-based standards for trauma-informed care that can be used by all out-of-home care treatment alternatives, and now represents the component areas of this Learning Collaborative.

Methodology

The goal of the FTIC-LC is to ensure that state-funded mental health residential treatment facilities for youth in Florida will have a collaborative framework for implementing, monitoring, evaluating and sharing practices consistent with guiding principles of trauma-informed care. The mission for participating "target sites" in this Collaborative is twofold:

1. Improve capacity to deliver high-quality services and supports through the adoption and adaptation of trauma-informed care standards; and
2. Improve the ability of each participating organization to become a change agent in their region for the spread and sustenance of practices that are trauma-informed.

The Collaborative goals fall into six key categories. The ultimate goal of this Collaborative is for each participating site to achieve measurable improvements in each of these categories:

- Awareness and knowledge of trauma-informed care principles and practices;
- Skill in delivery of trauma-informed care practices;
- Fidelity to trauma-informed care principles and practices;

- Provision of training, supervision and support for using trauma-informed care practices;
- Youth engagement and satisfaction within residential settings providing trauma informed care;
- Improved functioning and outcomes for youth receiving trauma-informed care residential treatment;

Within this framework, three levels of practice are identified:

1. Organizational readiness practices;
2. Competent organizational, clinical and milieu practices;
3. Effective family and youth engagement specific to trauma-informed care.

Initial findings will offer a baseline of competencies from which to create "units of change" that include goals for leadership, clinical, and direct care staff. Findings will be based on three instruments adapted by the research team for use with the Learning Collaborative. These instruments are based upon the following assessments and adapted with permission from the authors.

Alfred, C., Markiewicz, J., Amaya-Jackson, L., Putnam, F., Saunders, B., Wilson, C., Kelly, A., Kolko, D., Berliner, L. & Rosch, J. (2005). *The Organizational Readiness and Capacity Assessment*. Durham, NC: UCLA-Duke National Center for Child Traumatic Stress.

Fallot, R. D., & Harris, M. (2006). *Trauma-informed services: A self-assessment and planning protocol, version 1.4*. Community Connections: Washington, D.C. (202-608-4796).

Traumatic Stress Institute of Klingberg Family Centers. (2008). *Trauma-informed care in youth serving settings: Organizational self-assessment*, 370 Linwood Ave. New Britain, CT. 06052. (802-832-5507).

Clark, C., Young, M., Jackson, E., Graeber, C., Mazelis, R., Kammerer, N., & Huntington, N. (2007). *Consumer perceptions of care*. Developed for the Women with Co-occurring Disorders and Histories of Violence Study, sponsored by SAMHSA.

Findings

Initial results from select sites will be compared to findings from the previous study that indicated overall low to moderate implementation of trauma-informed care practices at all three levels of practices. Anticipated results are as follows:

- Awareness and knowledge of trauma-informed care principles and practices – moderate to high implementation
- Skill in delivery of trauma-informed care practices – low implementation
- Fidelity to trauma-informed care principles and practices – low implementation
- Provision of training, supervision and support for using trauma-informed care practices – moderate implementation
- Youth and family engagement and satisfaction within residential settings providing trauma informed care-low implementation
- Improved functioning and outcomes for youth receiving trauma-informed care residential treatment – unable to assess.

It is anticipated that results will show higher implementation of trauma-informed care for the statewide inpatient psychiatric programs (SIPPs) due to more intensive training in the past year, and the benefit of a more controlled environment. It is also expected that youth and family engagement (including voice, choice and collaboration), and trauma-informed milieu practices will continue to be most challenging.

Conclusion

Implementation of trauma-informed care practices in youth residential treatment settings in Florida requires a systematic way to measure organizational readiness; identify existing organizational, clinical and milieu

Poster 29

Addressing the Mental Health Needs of Children Who Have Witnessed Domestic Violence

Presenting: Ilana Amrani-Cohen

Introduction

This poster will present findings from the treatment of an overlooked population at high risk of experiencing mental health problems; that is, children who have witnessed domestic violence against the very individuals charged with protecting and nurturing them. Although most research on domestic violence has focused on the victims, usually women, and the perpetrators, most often male, less attention has been paid to the children involved in these situations, particularly with regard to interventions designed to treat potential psychosocial effects.

According to U.S. Department of Justice figures, about half of the homes where domestic violence occurs have children under the age of 13. In Massachusetts, where the current study took place, approximately 43,000 children are exposed to domestic violence each year. The Governor's Commission on Domestic Violence in Massachusetts found that children who witness domestic violence are at "serious risk for developmental delays, symptoms of post-traumatic stress disorder, irreversible psychological damage, internalizing acceptance of violence as a means of stress management and conflict resolution, and replicating the violence they witnessed as children in their adult relationships and parenting experiences" (The Children of Domestic Violence).

Beginning in 2001, the Domestic Violence Unit of the Massachusetts Department of Social Services funded nine agencies across the state to develop, implement and evaluate a group-based treatment for children between the ages of 8 and 12 who witnessed domestic violence. The Guidance Center, Inc.(GCI), in Cambridge, MA, was one of the nine Department of Social Services-funded agencies and has continued to deliver this treatment and evaluate its effects even after the original project ended in 2006.

This poster will present the intervention model, including the curriculum that was developed collaboratively among the nine original agencies, as well as adaptations the GCI staff has made since its origin, based upon their subsequent experiences treating children who have witnessed domestic violence. The presentation will include a description of the children who have participated in these groups over the past six years and their psychosocial outcomes, including increased pro-social behavior, ability to identify and express feelings, conflict resolution skills, recognition of and intolerance for abuse, and safety planning skills.

Methodology

The treatment in this study is a 12-week curriculum-based therapeutic group intervention for children ages 8 to 12. The curriculum was developed by the nine participating agencies and adapted from a treatment manual developed by the Children's Aid Society in Ontario, Canada. (Children's Aid Society). It covers topics such as identifying feelings, defining abuse, safety planning, substance abuse, sexual abuse, and conflict resolution, each of which are related to the measured outcomes identified previously.

Instruments used to measure outcomes of the intervention included the Pediatric Symptom Checklist, a standardized assessment instrument completed by parents and used to measure changes in the child's emotional

and behavioral functioning before and after the intervention; a demographic questionnaire to capture descriptive information about the children and families served by the intervention; a checklist completed by the therapist leading the group for each child designed to indicate the child's functioning over time on the five outcome domains; a goal attainment scaling form completed by the child's primary caregiver, usually the mother, based on the caregiver's treatment goals for the child; and a satisfaction questionnaire also completed by the child's caregiver regarding the caregiver's estimation of the benefits of the treatment for the child.

Findings

Preliminary descriptive data indicate that the average age of participants in the groups was just under ten years of age. Half of the sample were girls. Three-quarters of the sample include children who were living with their mother and siblings; a small number were in foster care or in shelters, and a somewhat larger number lived with grandparents or other relatives. About half of the children had been abused themselves, either physically or sexually. Many (59%) of the group participants were receiving other services such as individual or family therapy or psychiatric care with medication monitoring. Well over half (61%) of the children had ongoing contact with the perpetrator of the domestic violence: 30% by phone, 48% during unsupervised visits, and 14% in supervised visits. In a small number of instances the perpetrator was still living in the home with the child.

Caregivers rated the children's behavior as improved during the time of the intervention as did the therapists leading the groups. The children reported increased safety planning skills, and knowledge about violence and conflict resolution skills. A high proportion (83.5%) of the goals set by participants were met or exceeded as indicated by goal attainment scaling.

Other findings regarding treatment of children who have witnessed domestic violence as well as analyses of the relationships between demographic and descriptive variables and treatment outcomes will be included in the presentation.

Conclusion

Children who witness domestic violence are at high risk of developing mental health problems related to this experience. As this study shows, a high proportion of these children are also victims of physical or sexual abuse which increases the likelihood of negative developmental and psychosocial impact. Further, many of these children continue to have contact with the perpetrator of the abuse and thus require skills to manage this relationship and insure their own safety. Successful engagement of the child's caregiver proved to be critical to the success of the group experience for the child. A discussion of ways to heighten this engagement, particularly with mothers who have been abused, will be part of this presentation.

References

- The Children of Domestic Violence: A Report of the Governor's Commission on Domestic Violence of the Commonwealth of Massachusetts*, 1997, p. 1.
- Children's Aid Society of London & Middlesex, Ontario, Canada, *Group Treatment of Children Who Witness Woman Abuse: A Manual for Practitioners*.

Poster 30

Needs and Services of Sexually Abused Children

Presenting: Renee Brown & Christa Labouliere

Introduction

Studies have shown that the occurrence of child sexual abuse (CSA) is positively correlated with internalizing emotional problems, such as self-harm behavior, PTSD, and depression (Cohen, Deblinger, Mannarino, & Steer, 2004). Receiving treatment as soon after the trauma has happened and continuing with treatment for a longer period of time are good predictors of outcome (Barker-Collo, 2001); alternatively, Stauffer and Deblinger (1996) found almost no symptom improvement in the absence of treatment for children who were sexually abused. Case managers in child welfare often hold the key to connecting children who have been sexually abused to appropriate mental health services. What is unknown is how well case managers function in this capacity, or if the services they recommend are actually received.

The current study is part of a larger evaluation of Florida's child welfare system. The goal was to examine whether appropriate treatment was recommended and received among sexually abused children in the child protection system. Three research questions were investigated: At varying levels of CSA severity and evidence: (1) What mental health needs are identified?; (2) What services are recommended?; and, (3) What services actually are being received? This research is the first to look at associations of sexual abuse severity, evidence of abuse, and service recommendations in the child welfare system.

Methodology

The sample consisted of nine children's case files from four child welfare case management organizations. Of the sample, 89% were female, 56% were African American, and ages ranged from 1-13 years old, with a mean age of 6.44 years old at time of case review.

The research team reviewed the cases onsite at case management organizations around Central Florida, using protocols developed as part of a larger study. Qualitative methods were used to code information obtained from cases, and correlational analyses were conducted to examine associations between characteristics of the child and service provision. A coding system was developed to establish categories of sexual abuse severity, evidence of sexual abuse, and specificity of services, with severity coded on a 3-point scale and evidence of abuse coded on a 4-point scale. Specificity of services in relation to need was analyzed categorically, and both recommendations of services and actual receipt of services were examined.

Findings

Child sexual abuse (CSA) was found not to exist in isolation of other types of maltreatment. There was a mean of 3.44 (SD 1.42) other types of maltreatment documented in addition to the sexual abuse allegations; other types of maltreatment included physical abuse, neglect, domestic violence in the home, emotional abuse, substance abuse in the home, and medical neglect. Three of the nine cases had specific sexual abuse treatment recommendations, but only one case actually received such treatment. Older children were less likely to receive a recommendation of CSA specific treatment ($r = -.886, p = .01$). The majority of the cases (78%) were recommended and received in-home counseling focused on family preservation. Correlational analyses indicated that higher levels of severity were associated with higher likelihood for evidence of abuse being documented ($r = .792, p = .05$). Ironically, higher levels of severity of abuse were inversely correlated with receipt of any counseling services ($r = -.676, p = .05$).

Conclusion

Despite the small sample size of our study, alarming and unexpected results emerged. First, the frequency at which child sexual abuse is co-occurring with other types of maltreatment is alarming, suggesting that families involved in the child welfare system are dealing with a multitude of other issues in addition to sexual abuse allegations. Second, while CSA-related interventions were often recommended for children, these services were rarely provided. Although the majority of cases received some type of counseling, it was rarely specific to CSA. Even more alarming, CSA-specific counseling was usually provided only to those children experiencing the least severe forms of sexual abuse, and those children with the highest levels of sexual abuse severity and evidence were the least likely to receive any services. These results suggest need for reform in the policies of service recommendation and provision in the Florida child welfare system, and greater consistency in assessment and intervention across case management organizations.

References

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- Cohen, J. A., Deblinger, E., Mannarino, A. P., & Steer, R. A. (2004). A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43, 393-402.
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Poster 31

Antipsychotic Medication Utilization Among Children Prior to Out-of-Home Care

Presenting: John Robst

Contributing: Norin Dollard & Mary Armstrong

Introduction

This study adds to the literature examining psychotropic medication use among youth. We analyze administrative claims data to assess utilization among children prior to being served in therapeutic out-of-home care (OOHC) settings. The goal is to better understand antipsychotic prescribing patterns for children with mental health needs, and to better understand treatment patterns for children prior to therapeutic out-of-home care. Utilization is high among children in structured treatment settings, but it also important to understand treatment patterns prior to entry into structured treatment settings to inform policy discussions on interventions designed to reduce the need for intensive treatment.

The study addresses three questions.

- What is the utilization of antipsychotic medications before out-of-home care treatment?
- Are there age, race, and gender differences in utilization?
- Is antipsychotic utilization associated with the type of OOHC placement?

Background

There are three out-of-home treatment settings in Florida: Sub-acute Inpatient Psychiatric Program (SIPP), therapeutic group care (TGC), and therapeutic foster care (TFC). The SIPP was designed for clinically eligible children who are high utilizers of inpatient psychiatric services. The goal is to reduce long-term psychiatric inpatient care by providing an alternative to general inpatient settings and by increasing the emphasis on community-based resources and family support. TGC services are residential treatment services for youth with emotional and behavioral issues. Developed as a step-down from more restrictive treatment placements, TGC is designed to provide a high degree of structure, support, supervision, and clinical intervention in a home-like setting. TFC services are intensive treatment services provided to youth with emotional and behavioral issues in a licensed therapeutic foster home.

A majority of children in foster care are being prescribed antipsychotic medications (Zito et al., 2008). Several studies examine differences across demographic groups. Males are more likely to be prescribed antipsychotics than girls (Aparasu & Bhatara, 2007). There is no such consensus on race with some finding whites are most likely to be prescribed antipsychotics (Olson, Blanco, Liu, Moreno, & Laje, 2006), while others find blacks are more likely to be prescribed than whites (Gersing, Burchett, March, Ostbye, & Krishnan, 2007). Older children are more likely to be prescribed antipsychotics than younger children (Aparasu & Bhatara, 2007).

Methods

Medicaid claims data are analyzed for children receiving out-of-home care (SIPP, STFC, or TGC) in fiscal years 2003-04 through 2005-06. For the 6 months before each OOHC episode, we determine the number of days an individual had a prescription for an antipsychotic medication. Six atypical antipsychotic medications are included: Olanzapine, Ziprasidone, Clozapine, Quetiapine, Risperidone, and Aripiprazole.

The methods are descriptive. Utilization is measured by the proportion of children receiving antipsychotic medications, adherence, and consistency of treatment. Adherence is based on the medication possession ratio (MPR), measured as the proportion of days for which an antipsychotic was

prescribed in the 6-months prior to admission. Consistency indicates the number of months the individual has a $MPR \geq .5$.

Results

The sample includes 2,429 OOHC episodes (1,080 SIPP episodes, 860 STFC episodes, and 489 TGC episodes). Nearly 51% of episodes involve children and youth with antipsychotic prescriptions in the prior 6 months. Of those prescribed antipsychotic medication, the medication possession ratio was .70. The MPR was quite similar regardless of whether they are subsequently admitted to SIPP, TGC or STFC. Boys (55% v. 53%) were slightly more likely to be given antipsychotics, and to take the medication for more days (130 v. 117). Similarly, a greater percentage of the 6-12 age cohort was prescribed medication (56%) and had a higher MPR (.73) than the 13-18 age group (50% and .68). The penetration rate was similar for Whites and Hispanics (52% and 53%), and lowest for Blacks (46%).

Individuals with diagnoses of schizophrenia and psychoses had the highest penetration rates, but one of the lowest medication possession ratios. Over half of the youth with a diagnosis of Attention-Deficit/Hyperactivity Disorder (ADHD) had taken antipsychotic medications in the prior 6 month period.

Nearly 19% of the youth had a $MPR \geq .5$ for all 6 months. Consistent use was more likely among youth who had a Baker Act evaluation or another OOHC episode in the prior 6 months. Utilization increased over the first five months followed by sharp decline in the month prior to admission for children entering SIPP and TGC.

Discussion

We found the majority of children and adolescents in out-of-home care received antipsychotic medications prior to the therapeutic care episode. Some differences existed in treatment patterns across age, gender, and racial groups prior to OOHC treatment. Utilization was higher among youth ages 6-12 compared to those 13-18, which suggests that older children more often refuse to take medications due to the side effects (e.g., weight gain, type II diabetes). Among diagnoses, youth with schizophrenia or psychosis were most likely to be prescribed antipsychotics. The FDA has approved Risperidone and Aripiprazole for teens diagnosed with schizophrenia.

Utilization fell in the month before entering more restrictive settings (TGC and SIPP). This may be an area for policy intervention (e.g., education of caregivers and/or case management). Future work needs to establish the causal relationship between adherence and treatment placement.

A majority of youth diagnosed with ADHD are prescribed antipsychotics. Best practice guidelines state that antipsychotics are appropriate only when youth also experience psychotic episodes or exhibit aggressive behaviors. Future work should examine whether medications are appropriately prescribed to this population.

References

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Olfson, M., Blanco, C., Liu, L., Moreno, C., & Laje, G. (2006). National trends in the outpatient treatment of children and adolescents with antipsychotic drugs. *Archives of general Psychiatry*, 63, 679-685.

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Poster 32

The National Workgroup to Address the Needs of Youth Who Are LGBTQI2-S and their Families in Systems of Care

Presenting: Sylvia K. Fisher & Jeffrey M. Poirier

Overview

Youth who are lesbian, gay, bisexual, transgendered, questioning, intersex, and two-spirit (LGBTQI2-S) are frequently underserved in all mental health sectors, including systems of care. In some cases, the social censure for these youth is still considerable and has created a climate that is not conducive to these youth seeking needed assistance from mental health providers. In addition, youth who are LGBTQI2-S youth in systems of care may also have mental health challenges, which can result in a double stigmatization for them.

Strategies

With these concerns in mind, the Child, Adolescent and Family Branch (CAFB) in the Center for Mental Health Services located within the Substance Abuse and Mental Health Services Administration adopted a public health model to address the needs of youth who are LGBTQI2-S and their families. The CAFB recognizes that systems of care need evidence- and practice-based materials and supports for youth who are LGBTQI2-S and their families, preferably grounded in research findings about best practices and interventions. Accordingly, the CAFB has initiated a national workgroup to support and enhance services and supports, as well as increase the availability of much-needed resources and materials for these individuals and their families. The workgroup is comprised of an array of experts who are providing guidance and ongoing input on CAFB efforts to address the needs of these youth and their families. Members of the workgroup are helping to identify specific strategies and interventions that can be applied within the SOC program and throughout communities across the country. Moreover, the workgroup is guiding CAFB efforts to develop policies, programs, materials, and other products that will help address the needs of youth who are LGBTQI2-S and their families.

This poster will present the workgroup's logic model, which is grounded in findings from the research literature, best practices, and program efforts and is guiding the workgroup's efforts. The logic model includes the workgroup's population of focus, purpose, mission, and vision; challenges confronting the population of focus (e.g., consequences of stigma, isolation, disparities in access to health care, etc.); and the principles that underlie the workgroup's efforts (e.g., promote a public health framework for the provision and delivery of services and supports). It also includes anticipated goals and outcomes of the workgroup such as reduction of shame, stigma, and discrimination among youth who are LGBTQI2-S and their families. Furthermore, goals for the workgroup's efforts are organized into three strategies: promoting full inclusion in system of care communities; supporting development and implementation of culturally and linguistically competent and appropriate policies, programs, resources, and materials; and fostering collaborative relationships.

Resources

As a part of the national workgroup's strategy to address goals identified within the logic model, members are currently reviewing relevant, extant resources and materials that address cultural competence and mental health disparities, especially those that are based on research and effective practice. This scan of resources is currently underway. After the resources are vetted by workgroup members, the workgroup will produce a CD for dissemination to SOC communities. In addition, a practice brief has been developed and disseminated to enhance the cultural and linguistic competence of services for youth who are LGBTQI2-S and their families. Copies of this brief and other materials and resources that can be used within system of care communities to address the needs of this traditionally underserved population will be shared.

Monday, March 2 Events

7:30 am	Registration & Networking Breakfast
8:30 am	Opening Plenary: Abraham Wandersman
10:45 – 11:45 am	Concurrent Sessions 1–7
12:00 – 1:15 pm	Research Luncheon
1:30 – 3:00 pm	Concurrent Sessions 8–14
3:15 – 4:45 pm	Concurrent Sessions 15–21
5:00 – 6:00 pm	Concurrent Sessions 22–28
Dinner on your own	

Monday Plenary

8:30 AM Salons E & F

Welcoming Remarks

Robert M. Friedman, PhD, Director, Research and Training Center for Children's Mental Health, Louis de la Parte Florida Mental Health Institute, University of South Florida

System of Care Values in Research and Evaluation

Abraham Wandersman, PhD, University of South Carolina-Columbia; Vanessa A. Fuentes, Legal Assistant, Advocates for Children, New York, NY; and Brianne Masselli, THRIVE Initiative: Trauma Informed Systems of Care, Lewiston, ME

Contributing: Elaine Slaton, Federation of Families for Children's Mental Health, Washington, DC

This session will focus on the inclusion of system of care values and principles in research and evaluation. Much as systems of care emphasize partnerships with families and youth in system planning and development, so should such partnerships be developed in identifying questions to be studied and general approaches to be used in our research and evaluation. A panel including two young adults (Vanessa Fuentes and Brianne Masselli) and one researcher who has specialized in empowerment evaluation and community-based research (Dr. Abe Wandersman) will address this issue.

Monday Special Sessions

1:30 - 2:30 PM – Meeting Room 11

Special Issue Discussion

Cultural Competency: What is "Mental Health" in Indigenous, Island, and Immigrant Populations?

Panel: Jennifer Dewey & Freda Brashears, Macro International Inc., Atlanta, GA; Ranilo Laygo, University of Hawaii, Manoa, Honolulu, Hawaii; Bonnie Brandt, University of Guam, Mangilao, Guam

This discussion will explore the meaning of mental health for indigenous, island, and immigrant populations, and the cultural dimensions that impact access, utilization, and satisfaction with mental health services in systems of care. National evaluation staff will provide context and conduct a mapping process for participants to identify these populations within their cities, counties, and states. System of care community representatives will present their experience and related data on this topic.

3:15 - 4:45 PM – Meeting Room 8-10

A New Report from the National Research Council and Institute of Medicine: Preventing Mental, Emotional and Behavioral Disorders Among Young People: Progress and Possibilities

Panel: C. Hendricks Brown, Professor of Epidemiology and Biostatistics at the College of Public Health, University of South Florida; Peter Pecora, Senior Director of Research Services, Casey Family Programs; & Mary Ellen O'Connell, Senior Program Officer, Institute of Medicine and National Research Council

On February 13, 2009, the National Research Council and Institute of Medicine released a new report, Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. The report summarizes the progress made in prevention research over the last 15 years and prioritizes the research agenda for the future. It examines definitions of prevention, the developmental, epidemiologic, and ecological bases for developing and testing preventive interventions and reviews the progress made from rigorous experiments across the life span and contexts. It also outlines advances in genetics and neuroscience, and implementation science, that offer new opportunities for conducting prevention research and moving these prevention programs that benefit our children much more broadly into community, social service, and institutional settings. The panel will present this newly released report, with a focus on recommendations relevant to research and policy.

Monday, March 2 » 10:45 am

Session 1 Salon A-B	A Research Agenda for Protecting Our Children and Youth in Residential Programs Page 47 <i>Chair: Robert M. Friedman</i> <i>Robert M. Friedman, Lenore Behar, Christina Klover-Young & Brian Lombrowski</i>
Session 2 Salon C	Symposium—Structure and Role of Information Management in Systems of Care Page 48 <i>Chair: Vicki Effland</i> <i>Discussant: Knute Rotto</i> Components of an Information Management System <i>Vicki S. Effland & Shannon R. Van Deman</i> Identifying Core Information Needs <i>Ann E. Klein</i> Quality Improvement and Decision Making <i>Shannon R. Van Deman & Rahel Tekle</i>
Session 3 Salon D	Symposium—What Works, What We Think Works, and How It Can Work for You Page 51 <i>Chair: Krista Kutash</i> <i>Discussant: Michael Epstein</i> Can You Handle the Truth? Understanding What Works Clearinghouse Standards of Evidence <i>W. Carl Sumi</i> Does Practice Make Perfect? What the IES Behavior Practice Guide on Reducing Behavior Problems Can Offer You <i>Michelle Woodbridge & Michael Epstein</i>
Session 4 Salon G	Measuring Family Outcomes in Family to Family Support: Development of a Family Needs and Strengths Assessment (FANS) Page 53 <i>Nancy Craig, Vicki McCarthy & Marleen Radigan</i> Using a Community of Practice to Define the Role of Family Partners in Wraparound Page 54 <i>Marlene Penn, Trina Osher & April Sather</i>
Session 5 Salon H	Symposium—Advances in Services for Transition Age Youth Page 55 <i>Chair: Maryann Davis</i> <i>Discussant: Craig Anne Heflinger</i> Identifying and Helping Transition Age Youth at Risk of Arrest <i>Maryann Davis & Ashli Sheidow</i> Better Linkages between Child and Adult Services; a Social Network Analysis <i>Nancy Koroloff & Maryann Davis</i>
Session 6 Salon I	Gender Differences in Patterns of Child Risk across Programmatic Phases of the Children's Mental Health Initiative Page 58 <i>Melissa Azur & Lucas Godoy Garazza</i> Lessons Learned from the National Evaluation of the Comprehensive Community Mental Health Services for Children and their Families Program: Community Voices of Experience Page 59 <i>Connie Maples & Laura Whalen</i>
Session 7 Salon J	Symposium—Bring It Home: Using the National Longitudinal Outcomes Study for Local Evaluation Page 60 <i>Chair: Matt Wojack</i> <i>Discussant: Jane Powers</i> Local Continuous Quality Improvement Process and Findings <i>Matt Wojack & Jane Powers</i> Methodology for Retrieving and Presenting Local Data from the National Evaluation <i>Craig Wiles</i> National Evaluation Support to Help Communities Maximize Use of the Data <i>Kurt Moore</i>

Session 1 » 10:45 -11:45 am » Salon A-B

Symposium

A Research Agenda for Protecting Our Children and Youth in Residential Programs

Chair: Robert M. Friedman

Presenting: Robert M. Friedman, Lenore Behar, Christina Kloker-Young & Brian Lombrowski

In recent years there has been increasing attention paid to the alarming problem of youth being placed in private (often for-profit) residential programs purporting to be providing effective treatment for emotional and behavioral problems but instead, all too often, these programs offer severe discipline, inadequate treatment by ill-prepared staff, restricted contact with families, and emotional or physical abuse. Efforts to address this problem have been hindered by the absence of a strong research base describing the dimensions of the situation, and its impact on children, youth, and families. In this symposium, several members of the Alliance for the Safe, Therapeutic, and Appropriate Use of Residential Treatment (A START) will offer a framework for such research, and identify specific research questions that need to be addressed. The focus will be on newer, for-profit programs that serve youth from around the country rather than community-based non-profit residential programs.

Introduction

The symposium will be moderated by Bob Friedman, who will begin by discussing the problem in general terms. He will then offer a framework for identifying such programs, along with descriptive dimension, focused on the characteristics of the youth and families, and of the programs that are involved. Discussions of the various stages of the process by which youth and their families are affected by such these programs will include (a) the actual treatment they receive in the program, the involvement of families once a placement is made, (b) the marketing of the programs and the process of transporting youth to the programs, and (c) current research on the impact of such programs on the youth themselves.

Youth in Residential Programs and their Families: "Behind the Scenes"

After an overview and introduction to the problem of these residential programs, Lenore Behar will present a discussion of research questions in two areas: (1) information on the youth and families who use these programs; and (2), information about what goes on in the programs. Both represent serious challenges in research and evaluation design.

There is little systematically collected information about how youth and families get to unregulated and/or abusive residential programs. Some are referred by mental health providers, educational consultants, or schools. Others identify these programs using the Internet. One essential question in deciding to apply to a residential program is how those decisions are made and based upon what information. A second question is what information is used by the program to determine whether or not the placement is appropriate.

Little is known about how (or if) individualized service plans are developed in such programs, how progress is measured, and what the outcomes are. There is little information about services to the parents and the impact of those, or about how discharge planning is coordinated with local treatment providers and schools.

Marketing Residential Programs

Next, Christina Kloker-Young will discuss the marketing of these residential programs, the transport process from the youth's home to the

programs, and the effects of the programs on the family (including non-custodial family members).

There are no "Consumer Reports" documentations by an independent non-profit consumer-testing organization that surveys millions of consumers about their experiences with these places, products, and services. There is very little research done by independent sources on the effects of the marketing of these programs on the buyers. Often, the buyers of these expensive programs are given information by "educational consultants." These consultants frequently have very little information on the real way youth are handled at these programs. Marketing is also often through the Internet. An essential question to study is to learn about the marketing tactics that are used, and to learn how the marketing and high pressure tactics influence the buyers.

Often the youth who is to enter a program is removed from his/her home in the middle of the night after being woken up. The youth are unaware of where they are going, going against their will, and often are placed in some type of restraint. They are then delivered to strangers in a program that can be hundreds or thousands of miles from their home.

A third question in need of study is the effects on the family, including non-custodial parents, when a youth is placed in one of these programs, and contact with the family is denied or, at best, monitored. This is an especially important issue for families where there has been divorce or death of one parent, or where custody may be with only one parent. The effects of turning any family or community support member into an enemy by telling the youth that the family did not try to make contact needs to be studied. Similarly, there needs to be research on the effect on the parent-youth relationship when parents are told not to believe anything that their youngster says because it is typically a lie or an attempt at manipulation.

Impact on Youth – Existing Research

The final presentation will be by Brian Lombrowski, who will focus on the available research on the impact of these programs on the youths themselves. This presentation will involve a review of prior studies, including the research done by the Government Accountability Office. Special attention will be paid to the degree to which outcomes that are reported have been gathered by independent evaluators operating without conflicts of interest in a manner consistent with professional standards.

Based on the review of the current research, it is clear that there are important unmet needs, and very little research or evaluation has been done by independent evaluators. The work of the GAO is an exception but this is really not focused on outcomes of programs. Given the proprietary interests of many of the programs, there is a risk that research that is done by program staff itself will not be objective, and will be misleading. This presentation will not only identify specific research needs, but also will talk about the risks of research that is not conducted properly. Such research may present erroneous or misleading information that is used as part of a marketing effort.

The overall conclusion of the presenters is that despite the fact that thousands of youth are placed in for-profit residential programs each year that are distant from their homes, there is a glaring absence of research on all aspects of the process, from marketing to entry into care, to the program itself and its impact on the youth and their families.

Session 2 » 10:45 -11:45 am » Salon C

Symposium

Structure and Role of Information Management in Systems of Care

Chair: Vicki Effland

Discussant: Knute Rotto

Access to timely, accurate and comprehensive information about all aspects of a system of care is essential to achieving sustainability and providing effective services to youth and families. Choices, Inc., which manages systems of care in Indianapolis, Indiana, Cincinnati, Ohio, several sites in Maryland including Rockville and Baltimore, and Washington, DC, has developed an information management team and infrastructure that allows Choices to be accountable to its funders and community partners, identify areas for quality improvement, manage operations in multiple locations and communicate effectively about results. The symposium is presented by Choices' outcomes and evaluation team and financial risk manager, with discussion by Choices' CEO to emphasize the value this information management system brings to the systems of care represented. Part 1 of this symposium defines the basic components of the information management team and infrastructure, including technology, human resources, and a supportive organizational culture. Part 2 illustrates how this basic structure has allowed Choices to meet unique funding and reporting requirements in three states. Part 3 will focus on using information for internal decision making. Specifically, using information to manage financial resources and improve the quality of services will be discussed. Throughout the symposium, an emphasis is placed on developing an effective information management system, regardless of whether the SOC has staff dedicated specifically to this function. The advantages and disadvantages to having internal capacity to manage this information compared to working with an external evaluation team will also be discussed.

Components of an Information Management System

Presenting: Vicki S. Effland & Shannon R. Van Deman

Introduction

An effective mechanism for managing clinical, fiscal and outcome information is a necessary component for system of care implementation (Hodges, Friedman, & Hernandez, 2008) and sustainability (Stroul & Manteuffel, 2008), as well as developing effective finance strategies (Pires, Stroul, Armstrong, McCarthy, Pizzigati, Wood & Echo-Hawk, 2008). For example, Hodges, et al. state that "system planners and implementers must look beyond the accountability functions and move forward with processes of internal evaluation (p. 77)." Stroul and Manteuffel suggest that "...data collection to track service delivery and outcomes...should be a high-priority activity (p. 236)." Therefore, understanding the components of an information management system is necessary for all communities working to implement a system of care.

Technology Infrastructure

To collect the depth and breadth of information required in a system of care, an electronic process is the most efficient and beneficial because information can be extracted, manipulated, and combined with little effort. The most basic infrastructure required for this type of technology platform includes hardware, software, and a network.

The way we meet these infrastructure requirements at Choices is by equipping every care coordinator with a desktop or a laptop and by providing them access, through our network, to our electronic database.

Most information collected by Choices is obtained through regular interactions care coordinators have with enrolled youth and families. Specifically, care coordinators use The Clinical Manager (TCM) database to track youth enrollment dates, complete a strengths and needs assessment, develop plans of care and crisis plans; track utilization of services (service type, provider, units, costs); write contact and progress notes; and document members' living arrangement, educational status, contact with the juvenile justice system, and other key information elements. Information recorded in TCM serves as the clinical record for each youth enrolled. Project managers and supervisors access TCM's reports to provide clinical support to staff, manage fiscal aspects of the project, and make other key decisions. Choices' outcomes and evaluation team retrieves data directly from TCM's relational data tables, and the finance team relies on TCM data to invoice funders and pay providers for services delivered to children and families.

Choices employs a team of five Information Technology (IT) staff to manage the computer network, provide technical support to users in all of Choices' sites, and continually enhance Choices' technology infrastructure. The IT team works closely with the outcomes and evaluation and finance departments, project directors, supervisors, and staff across all of Choices' programs to effectively manage this technology infrastructure.

Staff Skills and Abilities

Choices has several staff dedicated to managing information across the organization, including the five IT staff mentioned above, three outcomes and evaluation staff, and a financial risk manager. Since not all organizations have the resources to hire staff into specialty roles, the following describes basic knowledge, skills and abilities required to effectively manage information so other organizations can identify a team of existing staff to effectively manage their information needs.

Core competencies required for an information management team appear in Table 1.

Table 1
Core Competencies Required for an Information Management Team

<i>Skills</i>	<i>Abilities</i>	<i>Work Activities</i>
Strong computer skills	Inductive & deductive reasoning	Analyzing data & information
Mathematical skills & comfort with basic statistics	Oral & written communication	Collecting & processing information
Critical thinking	Communicate effectively with individuals at all levels of technological familiarity, skills, & comfort	Communicating with supervisors, peers, or subordinates
Complex problem solving	Initiative	Making decisions & solving problems
Active learning & listening	Work well in team environment	Updating & using relevant knowledge
Judgment & decision making	Complete tasks within established time lines	Establishing & maintaining interpersonal relationships
Detail oriented & organized	Project management	Organizing, planning, & prioritizing work

Organizational Culture

A data driven decision-making culture is perhaps the most important and often most challenging component of an information management system. Literature on creating change within individuals and organizations (e.g., Rogers, 2003) provides a framework in which to first assess where organizations are in terms of possessing a data-driven culture and then to begin to establish a supportive culture.

To successfully develop a data driven culture, it is useful to understand the characteristics of a well-developed and effective culture; therefore, characteristics of Choices' data driven culture are presented below.

- CEO and other organization leaders are interested in data, ask for data on specific issues, use information to inform decision making, and expect staff to use data
- Organization invests in the technology, staff and resources needed to collect and analyze data and to turn data into information.
- Current data and information is requested and used in every decision.
- Staff supervision includes an assessment of the consistency and accuracy of data collection activities.
- Ways to improve the collection, reporting and use of information are identified by all staff and further explored and implemented by an information management team.

Conclusion

The combination of technology, staff skills and an organizational culture that values data enhances systems of care and the supports offered to youth and families. The result is a system with strong quality control mechanisms, internal accountability, and the information necessary to drive sound decisions.

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Identifying Core Information Needs

Presenting: Ann E. Klein

Introduction

Researchers have identified the use of outcome and evaluation data as an essential part of implementing and sustaining systems of care (e.g., Hodges, Friedman, & Hernandez, 2008; Stroul & Manteuffel, 2008). Additionally, Kukla-Acevedo, Hodges, Ferreira, & Mazza (2008) investigated the activities and strategies used by successful systems of care to develop effective quality improvement processes. Two of the six activities discussed in their issue brief are relevant to the discussion about what data systems of care should collect: understanding system intent determines the type of data collected and relevant indicators engage partners (Kukla-Acevedo, et al.). The following discussion highlights how these two activities were included in the process used by Choices to identify key information needs of systems of care located in Indiana, Ohio, Maryland and Washington, DC and across Choices as a whole.

Method

The identification of outcome data for Choices has evolved over time. The process began by considering what information care coordinators need to do their jobs well (e.g., youth demographics, needs and strengths assessment, plan of care, current living arrangement, service contacts, authorizations for services) and is thus already being collected. Across all of Choices' sites, this information is entered into The Clinical Manager (TCM), Choices' electronic database. TCM was created as an electronic case management tool and its core functionality centers around creating a comprehensive clinical record that meets mental health documentation requirements.

As Choices expanded into Ohio and Maryland, the need to collect data on indicators important and relevant to local community partners (Kukla-Acevedo, et al., 2008) became even more critical. Specifically, additional data were required to effectively report on performance measures established by local and state funders. For example in Ohio, Hamilton Choices was asked to report on the absence of substantiated reports of abuse and neglect and whether the frequency and severity level of juvenile justice contacts decreased during enrollment. Maryland Choices was required measure the percent of youth attending school regularly. By using existing screens in TCM, care coordinators were able to collect necessary data and the outcomes and evaluation team was able to analyze and report progress on these measures.

During this period of growth, the need for an assessment tool that could be used across all projects to help inform the development of treatment plans, make level of care decisions and compare the outcomes of youth enrolled in Choices' multiple locations emerged. As highlighted by Kukla-Acevedo, et al. (2008), a thorough understanding of systems of care in general and Choices' model of providing high fidelity wraparound in particular was essential in identifying this tool. Ultimately, the Child and Adolescent Needs and Strengths (CANS) assessment (Lyons, 2004) was selected and integrated into TCM so that CANS data could be readily used for clinical decisions, linked to data elements already collected in TCM and to minimize data collection burden for care coordinators.

To further engage partners across Choices, a final set of data elements was necessary to more effectively communicate results to broader audiences (e.g., policy makers, community members) and to more effectively manage operations across multiple locations. For example, data on the ongoing success of youth after discharge from our services is an important indicator for many community partners and is consistent with the expectations that Choices has for youth who participate in our services.

Results

Choices' current set of outcome measures fits well into the multi-dimensional framework proposed by Rosenblatt (2005). This framework includes four outcome domains (i.e., clinical status, functional status, life satisfaction and fulfillment and safety and welfare), five respondent types and four contexts in which the identified outcomes occur (i.e., individual, family, work setting or school, and community). Specifically, Choices collects data on youth functioning at home, in school and in the community and focuses on the development of strengths, reduction of behavioral and emotional needs and risk behaviors, and improvement in caregiver functioning. Detailed information on services provided to youth and families, as well as the costs associated with those services are tracked.

Discussion

The flexibility of the current information management system allows Choices to meet the demands of funders in each site and to advance our knowledge of effective systems of care through cross-site research. The integration of a common assessment has allowed for comparisons of the efficacy of our sites in addressing needs and building individual and family strengths. This work has allowed us to engage our system and funding partners in meaningful discussions about our local systems and the areas in which they need to be strengthened or enhanced. Funders across our sites are no longer simply interested in a predetermined set of reporting requirements, but are looking to us to expand the knowledge and conversation around effective supports in their communities.

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Quality Improvement and Decision Making

Presenting: Shannon R. Van Deman & Rahel Tekle

Introduction

Recently, Kukia-Acevedo, Hodges, Ferreira, & Mazza (2008) identified six evaluation activities that systems of care need to conduct in order to continuously improve their system. The purpose of this paper is to provide examples of how Choices has implemented several of these activities in its own quality improvement process.

Multiple Measures

Kukia-Acevedo, et al. (2008) proposed that systems of care should collect data on multiple system, service and child/family outcomes in order to fully understand system behavior. An example of how outcome data has been used by Choices to improve the quality of services occurred in the Dawn Project. Specifically, through ongoing monitoring of service utilization data, Choices' information management team observed an increase in the number of youth using educational and social mentoring. Possible explanations for this increase included a fundamental change in the characteristics of youth served by the Dawn Project and the presence of more positive outcomes for youth who received mentoring than those who did not. Examination of available data, however, did not support these explanations. Thus, the increased utilization of mentoring was determined to be a system-level issue, in which educational and social mentoring was being provided, not to meet identified needs of youth or to enhance youth outcomes, but to meet the needs of overwhelmed educators and parents.

As a result, the Dawn Project developed a set of best practice guidelines to help care coordinators and child and family teams refocus on one of Choices' core tenets—needs aren't services. These guidelines clearly delineate what needs both educational and social recreational mentoring are best able to address. Specifically, educational mentoring is intended to help youth who have significant behavioral problems in school improve their educational performance. Social recreational mentoring is meant to be a clinical intervention to help youth improve their social skills and relationships. Additionally, these guidelines identify the amount of mentoring youth should receive in a month and require supervisor approval if the youth's child and family team believe additional supports are indicated. Since implementing these guidelines, the utilization of mentoring has gone down and care coordinators have reported that the guidelines help them focus the conversation on needs.

Cost-Monitoring

According to Kukia-Acevedo, et al. (2008) systems of care must be able to document ongoing cost savings to sustain funding support for the system. Traditionally, Choices has struggled to demonstrate cost savings because of limited resources and lack of available data for youth not served in the system of care. Because of a change in the way that the Dawn Project is funded, however, Choices' was able to demonstrate clear cost savings in one of its sites.

Youth referred to the Dawn Project are assigned to one of four service tiers based on identified needs and previous involvement with various child-serving agencies. The only difference between youth assigned to the two highest service tiers is whether the youth is placed in residential at the time of referral. The referring agency is required to pay a higher case rate for youth in residential (RTC tier) than for those youth placed in the intensive tier. The Dawn Project has been very successful in keeping youth in the intensive tier out of residential placements. This results in a large cost savings to the child-serving system.

Quality Improvement Supports System Development

Kukia-Acevedo, et al. (2008) discussed the importance of a quality improvement culture and ongoing examination of data for influencing system change. An example of the benefits of this comes from Choices' site in Montgomery County, Maryland where project leaders noticed that their sites' wraparound fidelity scores, as measured by the Wraparound Fidelity Index (Bruns, Suter, Force, Sather, & Leverentz-Brady, 2006), were lower than expected in some key areas. Through discussions with care coordinators and their family support partners, project leaders learned that caregivers and team members were having difficulty identifying elements of the child and family team (CFT) process, understanding and recognizing terms and concepts associated with wraparound, and becoming fully engaged in the process.

To address these issues, Maryland Choices developed a template for meeting agendas in PowerPoint and provided care coordinators with access to laptop computers and projectors to take to CFT meetings. This allows the coordinators to show the PowerPoint at the CFT meetings and to document the team's discussion in the PowerPoint while at the meeting. The template includes a review of core values, current team members, the team's mission, strengths and successes, and the youth's plan of care. Team members can provide pictures and other graphics to include in the PowerPoint and provide a visual representation of the youth's progress. Implementation of this tool and other quality improvements has contributed to improved scores on the WFI (from 81% to 85%).

Conclusion

The final activity highlighted by Kukia-Acevedo, et al. (2008) states that systems should hold themselves accountable by disseminating information broadly, to both internal and external audiences. Choices is always looking for new ways to be accountable to local communities and to further improve the quality of services available. For example, the information management team is currently working on a new way to hold care coordinators and supervisors accountable for their work by developing a clinical dashboard that would clearly highlight how coordinators are performing clinically, fiscally and with fidelity to Choices' practice model. Hopefully, the examples provided in this paper will help emphasize the importance of data for decision making and quality improvement, not only at Choices, but for all systems of care.

References

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Session 3 » 10:45 - 11:45 am » Salon D

Symposium

What Works, What We Think Works, and How It Can Work for You

Chair: Krista Kutash

Discussant: Michael Epstein

This symposium will first provide an overview of our understanding of the What Works Clearinghouse (WWC) standards of evidence for determining the rigor and quality of research studies, and we will show examples of designs that we believe meet and do not meet the WWC evidence standards. We will describe our understanding and experiences in working with the standards to assess the strengths and weaknesses of studies' methodology as well as to help us plan and carry out our own research—not only in the designing stages, but in the analysis and reporting process as well. Then, we will introduce an important new document, an IES Practice Guide entitled “Reducing Behavior Problems in the Elementary School Classroom,” developed by a panel of nationally recognized experts in the field of children's behavioral health. Released in September 2008, the practice guide was downloaded over 11,000 times within the first month, demonstrating the great need of parents and practitioners for practical advice on how to face challenging behavioral issues. Briefly summarizing the guide's recommendations, we will also discuss how the suggested processes and procedures can be adapted to a wide range of contexts for use in the field of children's mental health—by parents and practitioners (including behavioral specialists, social workers, school psychologists, counselors, administrators, and teachers) who support children with or at risk for behavior disorders.

Can You Handle the Truth? Understanding What Works Clearinghouse Standards of Evidence

Presenting: W. Carl Sumi

As part of the Institute of Education Sciences' (IES) goal to help educators and policymakers incorporate scientifically based research into their work, the What Works Clearinghouse (WWC) has established rigorous standards for the review of causal research. In this presentation, we will describe our understanding and experiences in working with the standards to assess the methodological strengths and weaknesses of different studies as well as to help us plan and carry out our own studies—not only in the designing stages, but in the analysis and reporting process as well.

We will discuss the operationalization of the evidence standards from our own perspective as researchers, and we will show examples of designs that we believe meet and do not meet the WWC evidence standards. (For more complete information about the WWC review process, please see the WWC website, www.whatworks.ed.gov, including updated evidence standards for reviewing studies (revised May 2008) available at: http://ies.ed.gov/ncee/wwc/pdf/study_standards_final.pdf).

The WWC standards consider many characteristics of a study to assess its rigor, including the:

1. type of design employed (i.e., randomized controlled trial or a quasi-experimental design, including regression discontinuity and single-case designs)¹,

¹ According to the WWC definitions, randomized controlled trials are studies in which participants are randomly assigned to an intervention group that receives or is eligible to receive the intervention and a control group that does not receive the intervention. Quasiexperimental designs are primarily designs in which participants are not randomly assigned to the intervention and comparison groups, but the groups are equated. Quasi-experimental designs also include regression discontinuity designs and single case designs. Regression discontinuity designs are designs in which participants are assigned to the intervention and the control conditions based on a cutoff score on a pre-intervention measure that typically assesses need or merit. This measure should be one that has a known functional relationship with the outcome of interest over the range relevant for the study sample. Single-case designs are designs that involve repeated measurement of a single subject (e.g., a student or a classroom) in different conditions or phases over time.

2. types of outcomes measured,
3. response and attrition rates, and
4. adequacy of statistical procedures.

In the process of reviewing evidence, the WWC contracts with researchers to collect studies of interventions that address the most pressing issues in education through comprehensive and systematic literature searches.

Research studies are first screened to assess their adequacy to be categorized and catalogued in the What Works Clearinghouse. Studies may not pass the initial screening for a number of reasons, including the following:

- **Evaluation research design.** Only study designs that provide the strongest evidence of effects are included in the WWC, such as: randomized controlled trials, quasi-experimental designs (including regression discontinuity designs), and single subject designs.
- **Time period.** Generally, the acceptable time period for studies are those conducted within the last 20 years. Such a time frame includes research that represents the current status of the field and was conducted with populations and in contexts that are generalizable to today's issues.
- **Relevant and adequate outcome measure.** Research studies must report on at least one relevant outcome that assesses an intervention's impact or effectiveness, and they must reliably quantify that outcome. For example, studies of an intervention's implementation or a literature review are not eligible for WWC review.
- **Relevant sample.** Studies must include relevant population samples, such as children of school age.
- Studies that pass the initial WWC screening then undergo a thorough review process, where certified raters review the study more closely and assign one of three quality ratings.
- **Meets Evidence Standards.** Studies assigned this rating are generally well-conducted randomized controlled trials (RCTs) that do not have problems with randomization or attrition, or regression discontinuity designs that do not have problems with attrition;
- **Meets Evidence Standards with Reservations.** Generally, studies assigned this rating are strong quasi-experimental studies that have comparison groups with demonstrated equivalence and meet other WWC Evidence Standards. Studies assigned this rating may also include randomized trials with problems in randomization or attrition, as well as regression discontinuity designs with attrition problems; and
- **Does Not Meet Evidence Screens.** These are studies that provide insufficient evidence of causal validity.

These quality ratings are based on various details of a study, so they are informative for us as researchers to understand in our designing studies, and in collecting and analyzing our data. As researchers, we need to examine a study's:

- **Design** characteristics (e.g., How are the intervention and comparison groups formed? Are there any confounds?);
- **Outcome** measures (Are the outcome measures clearly and logically defined? Are the measures and administration processes reliable and valid?);
- **Sample** characteristics (What are the type and number of participants? Was equivalence of groups determined? What are the response and attrition rates across groups?); and
- **Analytical methods** (Are the statistical methods appropriate, including accounting for pre-intervention characteristics, clustering, and/or multiple comparisons in the analysis? Are effect sizes presented?).

The IES Practice Guide (described in detail below) serves as a case study for use of this process to compile high quality evidence as outlined above. Additional sample vignettes of study designs will be presented to discuss characteristics that may help to determine quality ratings.

Does Practice Make Perfect? What the IES Behavior Practice Guide on Reducing Behavior Problems Can Offer You

Presenting: Michelle Woodbridge & Michael Epstein

The Institute of Education Sciences (IES) publishes documents called "practice guides" with the purpose of bringing the best available evidence and expertise to bear on educational challenges. Practice guides offer specific recommendations to tackle multifaceted problems. Each recommendation is explicitly connected to the level of evidence supporting it, as rated by the WWC standards of evidence (described in more detail in the preceding presentation).

This presentation, by two authors of a current IES practice guide on the topic of "Reducing Behavior Problems in the Elementary School Classroom," will describe the process for reaching consensus among a panel of experts, compiling high quality evidence, and formulating recommendations to assist parents and practitioners of young children with or at risk for behavior problems. The outcome is a product that we believe may offer practical suggestions to parents and a variety of professionals who work with children with behavioral health needs (such as behavioral specialists, social workers, school psychologists, counselors, administrators, and teachers).

The practice guide offers five concrete recommendations, which we will briefly summarize, for reducing the frequency of the most common types of behavior problems encountered with elementary school children. The guide focuses on strategies teachers can use on their own initiative within their own classrooms, while at the same time recognizing their occasional need for the support of other professionals within the school or in the community more broadly. In summary, the recommendations include:

1. **Identify the specifics of the problem behavior and the conditions that prompt and reinforce it.** Understanding why problem behaviors occur is a powerful tool for figuring out how to head them off or to reduce their negative impacts when they occur. The first recommendation emphasizes the importance of teachers equipping themselves with information about important aspects of problem behaviors in their classrooms—e.g., the specific behavior a student exhibits; its effects on learning; and when, where, and how often it occurs. This information can provide important clues as to the underlying purpose of the problem behavior, a foundation for developing effective approaches to mitigating it.
2. **Modify the classroom learning environment to decrease problem behavior.** The second recommendation points to classroom conditions or activities that teachers can alter or adapt to influence the frequency or intensity of problem behaviors. When a teacher understands the behavioral "hot spots" in her classroom in terms of timing, setting, and instructional activities, for example, she can proactively develop class-wide and individual student strategies (e.g., a change in the seating plan, or the order or pace of instruction) to reduce the contribution of these classroom factors to students' problem behaviors.
3. **Teach and reinforce new skills to increase appropriate behavior and preserve a positive classroom climate.** The third recommendation recognizes that, just as poor academic performance can reflect deficits in specific academic skills, some students' failure to meet positive behavioral expectations may result from deficits in specific social or behavioral skills. And just as direct instruction can help students overcome academic deficits, students can benefit from teachers explicitly teaching the positive behaviors and skills students are expected to exhibit at school. Showing students how they can use appropriate behaviors to replace problem behaviors and consistently providing positive reinforcement when they do can increase students' chances of succeeding in the social and behavioral domains.

4. *Draw on relationships with professional colleagues and students' families for continued guidance and support.* Recognizing the collective wisdom and problem-solving abilities of school staff, the fourth recommendation encourages teachers to reach out to colleagues within the school—other classroom teachers, special educators, the school psychologists, and/or administrators—to help meet the behavioral needs of their students. Similarly, by engaging family members, teachers can better understand their students' behavior issues and develop allies in intervening both at school and at home to help students succeed. When behavior problems warrant accessing the services of behavioral or mental health professionals in the community, teachers are encouraged to play an active role in ensuring that services address classroom behavior issues directly.
5. *Assess whether school-wide behavior problems warrant adopting school-wide strategies or programs and, if so, implement ones shown to reduce negative and foster positive interactions.* The fifth recommendation reflects an understanding that a teacher may be more successful in creating a positive behavioral environment in the classroom when there also are school-wide efforts to create such an environment. Just as teachers can document and analyze the nature and contexts of behavior problems in the classroom, school leadership teams can “map” the behavioral territory of the school and use the information both to develop prevention strategies and to select and implement school-wide programs for behavior intervention and support when warranted.

Several principles run throughout these recommendations that we think are also important to share. One relates to the importance of relationships in any focus on student behavior. Student behavior is shaped by and is exhibited and interpreted within a social context that involves multiple actors, multiple settings, and multiple goals. Positive behavior is more likely to thrive when relationships, at all levels, are trusting and supportive and reflect a shared commitment to establishing a healthy school and community.

Another principle that underlies the recommendations is the critical need for increased cultural competence in developing positive relationships in school and community contexts. As our school and community populations become increasingly diverse, all school staff are challenged to learn about, become sensitive to, and broaden their perspectives regarding what may be unfamiliar ways of learning, behaving, and relating.

This practice guide is intended to be useful to educators in the elementary school level, as well as to school- and district-level administrators, in developing practice and policy alternatives for implementation of effective prevention and intervention strategies that promote positive behavior. However, we recognize the need for and ability of school staff and parents to translate the recommendations into actions that are appropriate to their specific contexts. The panel honors the insights of parents and educators in understanding what will work in their schools, classrooms, homes, and communities. We intend these recommendations to emphasize processes and procedures that can be adapted to a wide range of contexts rather than providing specific “recipes” that may have limited applicability.

Session 4 » 10:45 - 11:15 am » Salon G

Measuring Family Outcomes in Family to Family Support: Development of a Family Needs and Strengths Assessment (FANS)

Presenting: Nancy Craig, Vicki McCarthy & Marleen Radigan
Contributing: John Lyons & Kimberly Hoagwood

Introduction

Family to Family Support (FS) programs in New York State Office of Mental Health (NYS OMH) provide an array of services to support and empower families with children and adolescents having serious emotional disturbances. FS is not a clinical program. The goal of FS is to reduce family stress and enhance each family's ability to care for their child. Services include, but are not limited to, education and information, individual advocacy, family support groups, skill building, and instrumental support (i.e., respite). Few studies have examined parent and caregiver outcomes associated with receiving FS services. In part, this is a function of the limited availability of measures responsive to parents' and caregivers' needs. This pilot study developed a unified data measurement system including journey mapping, family outcomes (FANS) and empowerment standards within 16 independent FS programs in 19 Counties in western New York state. The focus of this abstract is to describe the development of the FANS outcomes tool and to examine the prevalence of needs and needs met using the FANS for families who received FS.

Methods

The FANS was modeled on the Child and Adolescent Needs and Strengths Assessment (CANS) scale developed by Dr. John Lyons. Development of the FANS started with the review of family items on the CANS used by New Jersey, Kids Oneida, OMH & other versions of

the CANS tools. Thirty parent & caregiver specific items were selected for additional review. Questions were cross-walked with the NYS OMH program model components including: education and information, individual advocacy, family support groups and respite/recreation. Fifteen items were selected for inclusion in the FANS instrument. During the course of 2007 and 2008, 682 FANS were collected from 444 families who received FS in western NY. The prevalence of 'Needs' on each item was calculated from the first FANS collected from these 444 Families (Needs = score of 2 or 3 on each FANS item). Pre- and post-scores were compared for 193 families that had at least 2 FANS. *Needs Met* was calculated as movement from needs (2 or 3) to strengths (0 or 1) on each item. A comparison of the difference between the post and pre scores were used to indicate if a family was doing better, stayed the same or got worse on each item.

Results

The fifteen items included in the FANS were used to measure prevalence of needs on caregiver's talents/interests, recreation, optimism, social resources, listening ability, communication ability, organizational skills, involvement, knowledge of needs, knowledge of rights and responsibilities, knowledge of service options, satisfaction with youth's living arrangements, satisfaction with youth's educational arrangements, satisfaction with school participation, and satisfaction with current services. The top four prevalent needs were: caregiver's social resources (46%), followed by caregiver optimism (45%), recreational interests (42%) and knowledge of service options (38%). In terms of having needs met (yes/no) the top four areas were: caregiver's social resources (15%), followed by caregiver optimism (13%), knowledge of service options

(13%), and satisfaction with youth's education (12%). We also examined needs met in terms of whether families were doing better, stayed the same or got worse during their course of services in FS. The top four areas in which families improved were: knowledge of service options (26%), caregiver's talents and interests (25%), knowledge of rights and responsibilities (25%) and caregiver's social resources.

Conclusions

This pilot demonstrated the feasibility of introducing a unified data collection process and examining family needs and strengths for Family to Family Support programs in New York State. The FANS results indicated high levels of family needs in those areas targeted by FS programs:

education and information about mental health services, advocacy, social resources and respite. In addition, the results demonstrated that the areas where families had their needs met were the same areas where families had the highest levels of need. This pilot lends credibility to the work of FS in enhancing parents and caregivers' knowledge and skills to meet the challenges of raising a child with mental health issues. The FANS is being used in conjunction with parent empowerment training (the PEP project) for family advisors throughout New York State. Future work should investigate ways to integrate the FANS with measures of caregiver outcomes to improve monitoring of family support programs and strengthen family to family support as an integral part of mental health systems of care.

Session 4 » 11:15 - 11:45 am » Salon G

Using a Community of Practice to Define the Role of Family Partners in Wraparound

Presenting: Marlene Penn, Trina Osher & April Sather

Introduction

The purpose of this paper session is to explore participatory strategies for specifying practice while focusing on the role of family partners in the wraparound process for children and families. This presentation will address how the Family Partner Task Force of the National Wraparound Initiative (NWI) used a community-defined evidence approach to achieve consensus in defining and describing the role of family partners in the wraparound process (Penn & Osher, 2007) and creating tools that communities can use to implement the model in a manner that is consistent with the principles of wraparound.

Methodology

After being provided a description of the Family Partner role as it pertained to each of the 10 Wraparound Principles (Penn & Osher, 2007), participants in the community-based evidence approach participated in three separate rounds of data collection, based on the Delphi approach. Utilizing a web-based survey method, the first and second rounds of data collection were limited to only those on the Family Partner Task Force, while the third round included all advisors in the National Wraparound Initiative. Data for round one were collected in December 2006 and January 2007. In the first round, 12 respondents were asked whether they: (a) liked the description, (b) agreed with the description, and (c) had any feedback as to how to change or improve the description.

The second round was conducted in March and April of 2007, and there were 11 respondents. Similar to the first round, respondents were provided updated descriptions of the Family Partner role, and this time were asked if they would: (a) keep the description as is, (b) change the description, or (c) discard the description. If respondents answered "change" or "discard," they were then required to explain their reasoning.

The third and final round was collected between June and August of 2007. Respondents were asked to respond in the same fashion as respondents from the second round. Although respondents in the third round included members of the Family Partner Task Force, the survey was expanded to include all advisors on the NWI. The process can be summarized in Table 1.

Table 1
Survey Process History

<i>Dates</i>	<i>Survey Title</i>	<i>Respondent Group</i>	<i>N</i>
Dec 06-Jan 07	Role of the Family Partner on Wraparound Teams	Family Partner Task Force	12
Mar-Apr 07	Role of the Family Partner on Wraparound teams, Draft II	Family Partner Task Force	11
Jun-Aug 07	Role of the Family Partner on Wraparound teams, Draft III	National Wraparound Advisors	42

Findings

The community-based evidence approach to developing the role for family partners in the wraparound process and tools for implementation has yielded a model that is applicable across a wide spectrum of system of care communities. It has also facilitated acceptance and use of the model and development of tools to guide implementation.

Conclusion

The work of the Family Partner Task Force of the NWI has contributed significantly to system of care development in two primary ways. First, many systems of care are including family partners on their teams and are seeking guidance about the best way to do this. Second, the family partner model being presented is consistent with the definition and principles of family-driven care and practice. In both of these arenas, local values and culture influence practice and there is little formal research—in part because these are relatively new practices and there are few standards that can be used in studies of implementation or effectiveness.

The description of the role of the Family Partner in wraparound that was developed using this participatory approach is gaining wide acceptance as a model for practice in communities around the country. A foundation has been established for systematic study of the role of Family Partners in different contexts and their impact on a variety of factors associated with planning and service delivery for children, youth, and families. The Family Partner Task Force is continuing to use this approach to develop additional tools.

Reference

Penn, M., & Osher, T. W. (2007). *The application of the ten principles of the wraparound process to the role of family partners on wraparound teams*. Portland, OR: Portland State University, National Wraparound Initiative.

Session 5 » 10:45 - 11:45 am » Salon H

Symposium

Advances in Services for Transition Age Youth

Chair: Maryann Davis

Discussant: Craig Anne Heflinger

The goals of this symposium are to expose the audience to important advances services for Transition Age Youth. The first paper presents findings that identify TAY with serious mental health conditions that are a high risk group for imminent arrest, and introduce an adaption of an evidence based practice to reduce antisocial behavior and increase role functioning in this population. The second study investigated changes associated with implementation of a Federal TAY services grant in the relationships between organizations that served individuals in the TAY age range.

Identifying and Helping Transition Age Youth at Risk of Arrest

Presenting: Maryann Davis & Ashli Sheidow

Introduction

Numerous longitudinal studies of adolescents with serious mental health conditions have reported elevated rates of trouble with the law during young adulthood. In particular, they have not identified factors that can identify youth at imminent risk of arrest. Because youths in adolescent mental health systems have high arrest rates and are involved with mental health systems in adolescence, it is likely that crime prevention efforts can be targeted at them through their public system involvement if enough is known about who is at risk and when. Arrest prevention or reduction would likely lead to better functioning in young adulthood. The purpose of this paper is to present findings about groups of intensive users of the public adolescent mental health system; users that are at high risk for arrest, and for imminent arrest, what is available for intervention to reduce arrest risk during the transition to adulthood, and a current study that is developing an adaptation of an evidence based treatment for juveniles for use with young adults with serious mental health conditions.

Methods

The study of high arrest risk examined patterns of and risk factors for arrest from ages 7-25 in a statewide cohort of intensive adolescent public mental health system users. This archival study combines data from two statewide administrative databases; the Massachusetts Department of Mental Health (DMH) information system and the state's juvenile and criminal court database (CORI). The CORI contains data from all arraignments in the state's non federal criminal and juvenile courts. The combined database contains DMH individuals' demographic, and clinical characteristics, juvenile and criminal arrest histories, and use of key mental health services and arrest histories of all individuals who received DMH adolescent case management services between 1994 and 1996, with 1976-1979 birth years (males $n = 781$, females $n = 738$). Case management clients had serious emotional disturbance, defined as one of a list of clinical diagnoses plus significant functional impairment, and in need of intensive services.

The adaptation study is a feasibility study of a randomized clinical trial. This paper presents the lines of evidence used to design the adaptation, the version of the adaptation that will be used for the trial, and the methods of the trial. The study population will be 17.75-21 year olds with a serious mental health condition, served by child welfare, juvenile justice, or adult mental health services, that have had an arrest or release from incarceration in the past 8 months, and are currently living

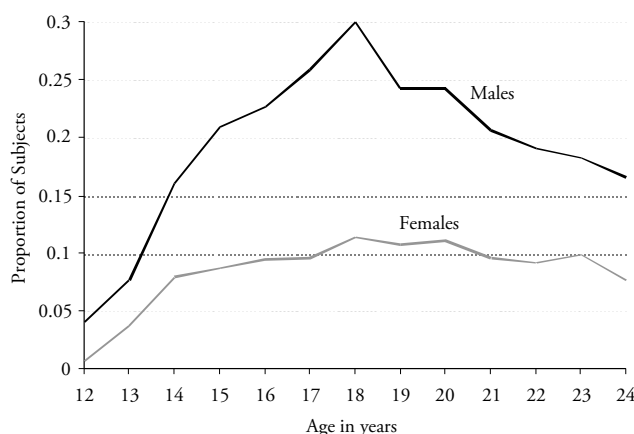
in a stable community based residence. Participants will be randomly assigned to the experimental intervention or services as usual. Major assessments will occur in person at baseline and every 6 months for 18 months, with briefer monthly telephone interviews.

Measures will assess the primary and secondary goals of treatment; reduction in antisocial behavior, reduction in mental health symptoms, reduction in substance use, increase in role functioning (school/work, independent living, parenting, and relationships with partner, family, and friends). Measurement will also assess service utilization and fidelity to the model.

Findings – Study 1

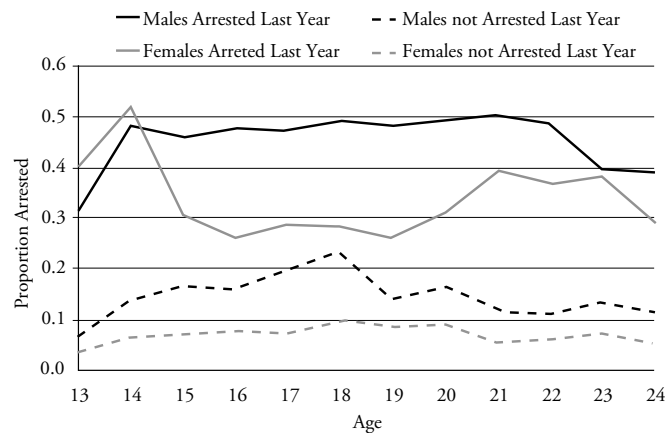
Overall, 57.9% of the DMH population had at least one arrest by age 25, this rate was significantly higher in males than females (68.9.0% vs. 46.3%; $\chi^2 (df = 1) = 79.13, p < .001$). Cross sectional arrest risk in males and female are presented in Figure 1.

Figure 1
Arrest Rates by Age And Gender within a Statewide Cohort of Public Adolescent Mental Health System Users (males, $n = 781$, females $n = 738$)



Multinomial regression analysis examining gender, race, adolescent diagnoses of substance use, major depressive, or anxiety disorders, residential treatment at ages 16-18, arrested the previous year, or ever arrested in the past for a violent crime on arrest at each age revealed two consistent factors which were significant at each age from 13-24; gender and arrest the previous year of age, Wald ($df = 1$), Gender = 6.9-44.3, $p < .01$; Previous arrest = 23.7-177.0, $p < .001$). Substance use diagnosis predicted arrest at 15 and 17, Wald ($df = 1$) = 13.0, 4.7, $p < .05$. Arrest rates in males and female arrested and not arrested the previous year are shown in Figure 2.

Figure 2
Arrest Rates by Age and Gender within a Statewide Cohort
of Public Adolescent Mental Health System Users
(Males, $n = 781$, Females $n = 738$)
When Having Been, or Not Been Arrested the Previous Year of Age



No other factors contributed significantly to arrest risk.

Discussion Study 1

While many factors that can predict arrest in the general population were not possible to examine with these data (e.g. parental supervision, antisocial peer affiliation), these findings indicate a strong and easily assessed predictor of arrest risk in the population of youth with serious mental health conditions during the transition to adulthood; arrest the previous year. Identifying a group that has a 50% or 33% possibility of imminent arrest (males and females, respectively, arrested the previous year) is an important tool for reducing subsequent offending. The necessary next step is identification of interventions that can effectively reduce the likelihood of offending in these high risk groups.

Study 2: Adaptation of MST

This literature review emphasizes findings on factors that contribute to offending and desistance in juveniles and adults, and when available, those with mental health conditions. Many factors associated with offending have been identified in general population juveniles and adults. For example, affiliation with deviant peers, lack of parental supervision/monitoring, and substance abuse are associated with offending in juveniles, whereas substance abuse, and lack of positive engagement in work have been identified in adults. There are no studies that have examined developmental changes in the factors that contribute to offending or desistance through young adulthood, therefore targets of intervention must be extrapolated from the younger to the older age group. When malleable risk factors for offending or desistance have been examined in the mental health population they are generally similar to those found in the general population. Taken in combination with the developmental changes of young adulthood, these findings are applied to an adaptation of Multisystemic Therapy (MST; Henggeler et al., 1998).

MST is an evidence based treatment for antisocial behavior in juveniles. It is an intensive, homebased treatment. The interventions integrated into MST are empirically-based clinical techniques from the cognitive behavioral and behavioral therapies. Intervention focuses on providing parents or parental figures tools to help change their child's behavior across the various ecologies that contribute to offending such as school, peers, family, and neighborhood.

Adaptation to MST for emerging adults with serious mental health conditions (MST-EA) has involved shifting the target of therapy from parents to young adults, identifying cognitive behavioral and behavioral approaches that are used with adults for implementation with young adults, and addressing mental health treatment needs, as well as other modifications that will be described. Design of the feasibility study will also be described (this research is funded by a grant from the NIMH R34 MH081374-01).

Conclusions

This line of inquiry has identified a high risk group of transition age youths with serious mental health conditions that would benefit from access to interventions that can help them reduce their offending behavior. It has also helped to initiate the development of an intervention that shows promise for achieving this goal for young adults with serious mental health conditions for whom there are currently no known effective approaches. Some of the approaches to treatment adaptation in the MST-EA model may provide guidance for the development of other treatments for transition age youth.

Reference

Henggeler, S.W., Schoenwald, S.K., Borduin, C.M., Rowland, M.D., & Cunningham, P.B. (1998). *Multisystemic Treatment of Antisocial Behavior in Children and Adolescents*. New York: Guilford.

Better Linkages between Child and Adult Services; A Social Network Analysis

Presenting: Nancy Koroloff & Maryann Davis

Contributing: Matthew Johnsen

This presentation will outline a social network analysis conducted in Clark County, Washington in order to describe changes in a social service system for youth who are transitioning from children's mental health services into adulthood. Clark County received a four year grant to expand the services available to youth with mental health disabilities receiving public mental health services as they transition into adulthood. As a part of this funding, the Options program was established. This program provides transition facilitators, employment and housing support and youth leadership opportunities. Data for this study were collected using a standardized social network interview augmented with questions specific to accepted guidelines for transition services.

Social Network Analysis (SNA) is a methodology that describes which organizations are in a network or system, the characteristics of each of those organizations, and the strength and direction of each organization's relationship to the other organizations in the network (Van de Ven & Ferry, 1980; Morrissey et al., 1994). By the term organization, we refer to the organization at a program level. For example, a mental health agency may offer 5 programs that serve adolescents or young adults; each of those programs would be considered an organization. The strength of interorganizational relationships are described along three dimensions; sharing of client referrals and information, sharing of staff, and sharing of resources. In this study we focused only on the sharing of referrals and the sharing of information. Using this information networks can be described for their size, the degree to which they are centralized, their density, and their subsystems. Characteristics of organizations at the center or periphery can be described (i.e. ages served, type of service offered, program size, adherence to TIP guidelines).

Briefly, SNA methodology consists of interviewing an informant within each network organization (Van de Ven & Ferry, 1980). Providers' self-report on interorganizational networks has been shown to be valid

and reliable (Calloway et al., 1993). For this study, informants responded to the following questions:

- 2.1 How often do staff in your program/agency meet with staff in this other program/agency for client planning purposes?
- 2.2 How often do staff or administrators in your agency/program and these agencies/programs meet together to discuss issues of mutual interest?
- 2.3 How often does your agency/program refer clients to this other agency/program?
- 2.4 How often does your agency/program receive client referrals from this other agency/program?

SNA data collection methodology was established for mental health organizational systems by Morrissey, Calloway, and colleagues (1994 & 1997). It has been used to successfully assess the contribution of service integration to client outcomes for a variety of populations including homeless adults with mental illness (Rosenheck, et al., 2002) and children with serious emotional disturbance (Johnsen et al. 1996).

One of the most critical aspects of SNA methodology is called “bounding the system” or identifying network members. Bounding is achieved through talking with those who centrally work with adolescents and adults with psychiatric disabilities in public sectors to find out all of the potential organizations and programs that might be utilized in a transition system. Some organizations will serve only adolescents, and others will serve only adults, and a smaller number will serve individuals across the adolescent/adult age barrier. Once the network is bounded a key informant is identified within each organization. The key informant is an organizational “boundary spanner” who has both extensive knowledge of the organization and global knowledge of interorganizational relationships between that organization and organizations in the area.

During the first phase of this network analysis, key informants in 103 organizations were interviewed. Four years later, key informants in 100 organizations participated. 85 programs participated in both waves of data collection. Table 1 describes the difference between the participants in the first phase of data collection compared to the second.

Table 1
How Did the System Change?

	<i>N</i>
In Wave 1 / not Wave 2	
Programs terminated	10
Programs merged	2
Refused interview	4
In Wave 2 / Not Wave 1	
New Program (started since 2003)	9
Program added (existed in 2003)	6

SNA requires the generation of organization-by-organization matrices for each of the types of relationships (referrals and information exchanges, staff sharing, resource sharing). We then calculate values for connections within and between youth and adult sub-systems. The density and centralization of the system as a whole, and of the sub system of the transition system were calculated using the UCINET program. The overall transition system is defined as adolescent programs that are linked to adult programs, vice versa, and those that are linked to programs that serve both adolescents and adults within the same program. K-core analysis is a method for describing subsystems within the system by highlighting organizations that share a high level of connectedness with each other (Johnsen et al., 1996).

Figure 1 presents the picture of the network as it existed at the first wave of data collection. It shows a well defined and connected network of children's services which is connected to a more isolated set of adult services through two central groups of programs. The two central groups consist primarily of organizations that provide funding, oversight and certification to the more peripheral programs.

Figure 2 provides a picture of the service system at time 2, after the Option program had been active in the community for four years. At time 2, the entire network is more connected shown by greater density of lines between nodes. The children's programs are more connected with the adult programs and the adult programs are less isolated. Two nodes have membership from both child and adult programs, designated in the Table as “mixed.” These mixed nodes did not exist at Time 1.

Figure 1
Block analysis results of social network analysis of 103 organizations in Clark County, WA, before implementation of a grant to offer transition support services

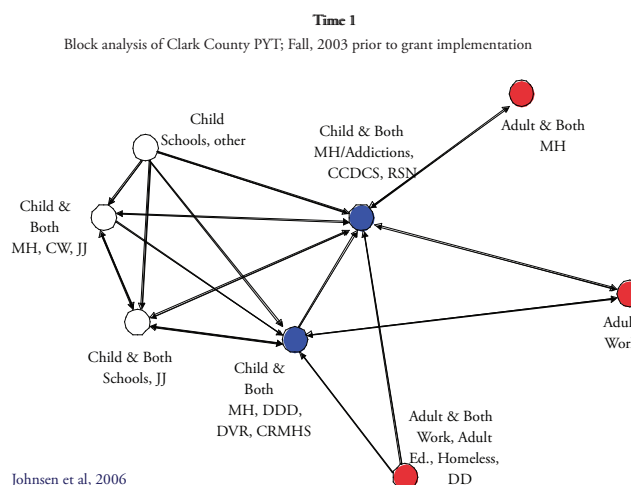
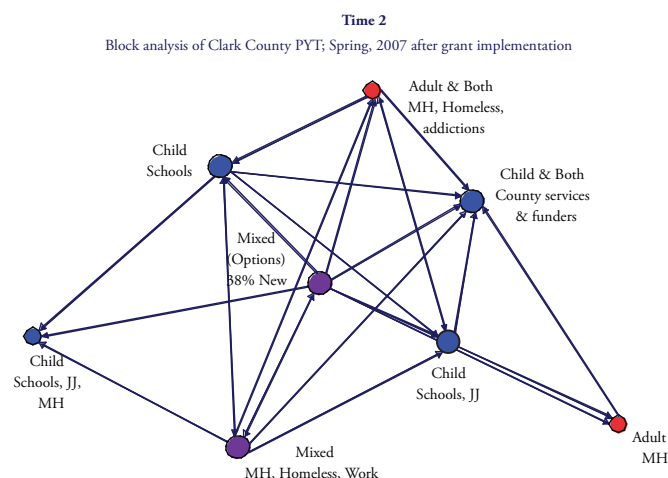


Figure 2
Block analysis results of social network analysis of 100 organizations in Clark County, WA, after implementation of a grant to offer transition support services



Summary

It appears that the collection of organizations that can serve transition age youth with serious mental health conditions had better communication between its child and adult components compared to baseline. Overall, at Time 2 there are no blocks of organizations as isolated as the 3 adult blocks at Time 1. Generally, the blocks were less age defined at Time 2. There were more child and adult agencies acting in similar fashions towards other organizations. There was much more direct communication between child and adult organizations. Further, some blocks, whose membership largely remained the same from Time 1 to 2, behaved in a different fashion such that there was more cross adult/child communication at Time 2.

These findings suggest that it is possible for child and adult programs and agencies to increase communication about clients and other shared interests, which may facilitate better transitions for youth with serious mental health conditions as they move into adulthood.

References

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Session 6 » 10:45 - 11:15 am » Salon I

Gender Differences in Patterns of Child Risk across Programmatic Phases of the Children's Mental Health Initiative

Presenting: Melissa Azur & Lucas Godoy Garazza

Contributing: Christine Walrath

Introduction

Previous research on gender differences in patterns of risk among children entering the Children's Mental Health Initiative (CMHI) suggests that there are groups of boys and girls with similar risk histories (Walrath et al., 2004). These children can be classified into low risk, abuse, status offense, and high risk groups. It is unclear whether these patterns of risk are consistent across the CMHI's funding history and if these patterns vary as a function of age or impairment. A better understanding of the characteristics of children entering services and whether those characteristics have changed over time will inform policy and planning efforts to provide services tailored to the specific needs of the child. To this end, the current study extends previous research and uses multi-group latent class analysis (LCA) to examine: (1) the extent to which risk patterns for boys and girls have remained constant across the CMHI's funding phase; (2) the relationship between age and risk patterns for boys and girls, and whether that relationship changes across funding phase, and; (3) the relationship between impairment and risk patterns for boys and girls, and whether that relationship changes across funding phase. Multi-group latent class analysis (LCA) is a flexible method that allows comparisons of class solutions across different samples without assuming that the different groups are the same.

Method

Sample

The data collected are from children ($N = 18,437$) who participated in the CMHI between 1994 and 2004. The study sample spans three federal funding phases and reflects sites that received their initial funding in Phase I (1993 & 1994), Phase II (1997 & 1998), and Phase III (1999

& 2000). Children were included in the sample if they were between 5 and 22 years of age and if there were available data on gender, referral source, race/ethnicity and the six child risk factors described below.

Measures

Child age, gender, race/ethnicity and referral source were collected from caregivers at the child's intake into services. History of physical or sexual abuse, substance abuse, running away from home, suicide attempt, and sexually abusing another individual were obtained from the caregiver at intake. Functional impairment was assessed with the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 1997).

Analysis

Multi-group LCA was used to examine and compare latent risk classes across the six gender-by-funding phase groups (e.g., boys in Phase I, girls in Phase I, boys in Phase II, etc.). Three, four, and five class models were developed and compared to a single class model. Model fit was assessed with Akaike's information criterion, Bayesian information criterion, and the likelihood ratio chi-square test.

To test the association between age and latent class membership, the best model was then refitted with age as a predictor of class membership. This process was repeated, adding functional impairment as an outcome of class membership.

Findings

Across phases, a four class model, for boys and girls, best fits the data. The classes can be described as high risk, status offense, abuse, and low risk. The high risk class included children who were most likely to have experienced each of the risk factors (except for girls who were unlikely to sexually abuse others). Consistent across funding phases, a greater proportion of girls belonged to the high risk class than did the proportion

of boys in the high risk class (e.g., 13.7% v. 2% in Phase I); however, this difference diminished across funding phases. The abuse class included children with a history of physical and sexual abuse. In Phases I and II, twice as many girls belonged to the abuse class than boys; however similar proportions of girls and boys belonged to this class in Phase III. The low risk class represented the largest proportion of both boys and girls, and represents children who were unlikely to endorse any of the risk factors. By Phase III, similar proportions of boys and girls belonged to this class.

The probability of class membership varied as a function of age. In general, older children were more likely to belong to the status offense and high risk classes than younger children. A smaller proportion of older girls belonged to the status offense class than the proportion of older boys in the status offense class. Conversely, younger children had a higher probability of belonging to the low risk class. With respect to functional impairment, boys and girls in the high risk class experienced the most impairment and boys and girls in the low risk class experienced the least impairment. Generally, girls in each class and across phases had less impairment than boys.

Conclusion

Multi-group LCA is a flexible method that not only allows a comparison of groups across samples, but also permits formal testing to determine whether groups are statistically different. Consistent with previous research, this study identified four sub-groups of children with

similar patterns of child risk. These groups showed similarities across funding phase for boys and girls, which suggests that the CMHI has consistently enrolled and served children with a range of histories and needs. Changes in the distribution of boys and girls in the risk classes suggests that over time more boys with complex histories of risk have entered into the system of care program. Information on children's exposure to child risk factors can aid service providers in identifying children who may need more intensive services. Information on how the pattern of children who enter into the system of care program has changed over funding phases will assist policymakers in developing programs to address the needs of vulnerable groups of children. Similar to the single-group LCA, the multi-group LCA is sensitive to additional information and, at times, findings can be challenging to interpret. Despite these limitations, multi-group LCA is a useful method to compare patterns among different groups.

References

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Session 6 » 11:15 - 11:45 am » Salon I

Lessons Learned from the National Evaluation of the Comprehensive Community Mental Health Services for Children and their Families Program: Community Voices of Experience

Presenting: Connie Maples & Laura Whalen

Introduction

Lessons learned from fifteen recently graduated communities of the Comprehensive Community Mental Health Services for Children and Their Families program provide guidance for current communities, technical assistance partners, and the national evaluation.

Methodology

The national evaluation team conducts close-out site visits to address data issues, to report results, and to give guidance about final services from the national evaluation. The visit also provides an opportunity to collect information about lessons learned on the topics of sustainability, services and costs, data quality and dissemination, recruitment and retention, logic models, community buy-in, and family and youth involvement. These lessons were captured in a site-level report provided to the Substance Abuse and Mental Health Services Administration (SAMHSA), the program funder. The national evaluation used ATLAS.ti (Muir, 2004), a qualitative data analysis tool, to capture lessons from communities, including Broward County, Florida; Chicago; Choctaw Nation, Oklahoma; Colorado; El Paso County, Texas; Fort Worth, Texas; Glenn County, California; Guam; Idaho; New York City; Oklahoma; Puerto Rico; San Francisco; and southwest Missouri.

Findings

Communities offered the following recommendations and observations on their experiences in implementing the national evaluation and building their system of care.

Sustainability planning must begin early in the federal funding cycle and include a variety of stakeholders to ensure program continuation. Core elements of planning include early identification of program outcomes to demonstrate progress toward outcomes over time, investing a portion of federal dollars for infrastructure development, and identifying Medicaid reimbursable services.

Data dissemination activities were useful in garnering political support for system of care services from local and state policy makers. Reporting data and identifying elements in data collection that were accessible only from other child serving partners helped build collaborations between mental health, child welfare, education and juvenile justice.

Important facilitators of strong recruitment and resulting retention of family members and youth into the program and the evaluation include having family members introduce the study and explain the costs and benefits to families as they entered services, hiring and maintaining data collection staff who were committed to developing and maintaining relationships with family members and youth, hiring data collection staff who were flexible in scheduling interviews at times and locations that were convenient for participants and providing participants with reports that illustrated improvements over time. Community events (e.g., fairs, holiday booths, instructional classes) and program branding promoted

participation in system of care services and the evaluation. Use of a centralized client tracking system coupled with vigilant collection and maintenance of contact information was essential to following families and youth over time.

Initial logic model development work was experienced as a positive community—building and educational activity around system of care principles. However, most sites reported that once the logic model was developed, it was rarely used. Factors affecting the lack of use included staff turnover in key leadership positions and lack of understanding and skills in effective utilization of logic models. Sites felt the logic model was a global view of their system of care and that it was useful for introducing new partners to their system. A few sites felt they required more detailed models or flow charts of tasks for effective utilization.

Recommendations for community buy-in to the program and to the evaluation included building in time for relationship building and relationship maintenance. Feedback on program and evaluation progress and frequent sharing of perceptions of local system of care definition were key factors in sustained partner engagement.

Family and youth involvement was most often achieved in the form of service on various committees and a governance council, and through social marketing activities. Over half of the sites successfully employed family members on their evaluation teams. Youth involvement was more challenging for most sites, and communities struggled to embrace the program's evolution from "youth involvement" in services to "youth guided" services. Sites felt that more should have been done to cultivate family and youth involvement. One site stated they wished they had done a better job of meeting the youth "where they were."

The quality and management of data for future sites can be improved through the implementation of the following activities: using an electronic tracking software program; employing a centralized data manager; reducing staff turnover; hiring bi-lingual interviewers, where appropriate; budgeting to meet the costs of increasing enrollment; and,

investing in professional development for staff to acquire and maintain key skills (e.g., technical skills in Excel and Access, supervisory and leadership skills).

Services and cost data were a challenge to collect and report as a part of the national evaluation protocol, with sites noting three core issues that future sites will need to address in order to access cost data. Collaboration between mental health and child welfare is essential in gaining access to billing records. Early and clear guidance on the type, frequency and duration of cost data is required. Consent forms must include language to access and share cost data for individual families and youth with the national evaluation.

Most sites indicated they suffered from the effect of staff turnover on all levels. New sites should focus on staff cohesion and satisfaction in building a system of care. From front line case managers to key leadership positions, the investment in staff was costly and had to be repeated in re-training new staff. The loss of relationships slowed the progress; whether it was retention in the outcome study, in services, or of a community partner in the system of care.

Conclusion

Lessons learned from graduated communities, particularly those around key topics of recruitment and retention, data quality, and data dissemination are valuable considerations for newly-funded communities as they establish a theory of change, involve family and youth in meaningful ways, promote community buy-in, and plan for sustainability. Some of the issues identified by sites have been or are being addressed by the national evaluation and other technical assistance partners.

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Session 7 » 10:45 - 11:45 am » Salon J

Symposium

Bring It Home: Using the National Longitudinal Outcomes Study for Local Evaluation

Chair: Matt Wojack

Discussant: Jane Powers

This symposium presents the experience of a community system of care in using the national evaluation of the Children's Mental Health Initiative (CMHI), integrated with local evaluation, to evaluate progress toward community-defined outcomes. The CMHI national evaluation has undoubtedly contributed to continuing federal support for systems of care, with its extensive monitoring of family and child functioning, service delivery, and system outcomes. It is equally important for communities to monitor indicators of local importance. Rather than create new data sources, it is less burdensome for communities to identify relevant national measures and "retrieve" the local data collected and submitted to the national evaluation. Since the retrieval of local data is challenging, sharing methods among community systems of care can be helpful. The symposium consists of three presentations: the integrated evaluation and performance measurement process of a community system of care and a review of findings that demonstrate progress toward community-defined outcomes; the methodology designed to retrieve the local data that is collected and submitted to the national evaluation

of the CMHI; and the assistance available from the national evaluation, including a comparative analysis of selected local and national outcome data. Presenters and participants will discuss performance improvement approaches driven by integrated local and national evaluation and share lessons learned from efforts to track local outcomes with data submitted to the national evaluation.

Local Continuous Quality Improvement Process and Findings

Presenting: Matt Wojack & Jane Powers

Introduction

This portion of the presentation will describe (1) how the Impact system of care in Ingham County, Michigan, is being strengthened by fully engaging stakeholders (families, youth, agency partners, and community institutions) in a continuous cycle of action, assessment, and refinement of action and (2) how data collected for the national evaluation contributes

to the assessment of local outcomes. The cycle of steps includes measuring indicators that are valued by the stakeholders, dialogue among the stakeholders to interpret data and create findings, and using the findings to modify key strategies. When the stakeholders designed the theory of change for the community's system of care, they defined the key strategies, goals, and outcomes, as well as the indicators and measures that comprise the local evaluation. Impact's key outcomes are:

Outcome 1: Maximized functioning of children with SED and their families

Outcome 2: Reduced need for out-of-home placements

Outcome 3: Efficient use of resources

Outcome 4: Increased participation of families and youth in the development of the system

Outcome 5: A unified, family driven, youth guided, and culturally and linguistically competent system of care for children with SED and their families

Outcome 6: Increased community knowledge of the system of care and decreased stigma

During the stakeholder dialogue to select meaningful outcome indicators and measures, the project's evaluation staff facilitated a review of the data collected for the national evaluation of the CMHI to identify the national data that could be used to measure progress toward local goals and outcomes (including child and family, service delivery, and system measures). For example, at the level of specific questions in the national data-collection instruments, the following national data were selected to measure indicators of progress toward two of the locally defined outcomes.

Outcome 1: Maximized functioning of children with SED and their families

- Youth Services Survey for Families (YSS-F) administered to caregivers, question 16 (As a result of the services my child and/or family received, my child is better at handling daily life.)
- Youth Services Survey (YSS) administered to youth, question 16 (As a result of the services I received, I am better at handling daily life.)
- YSS-F administered to caregivers, question 21 (As a result of the services my child and/or family received, I am satisfied with our family life right now.)
- YSS administered to youth, question 21 (As a result of the services I received, I am satisfied with my family life right now.)
- Education Questionnaire (EQ-R) administered to caregivers, question 3 (When school was in session, did [child's name] miss school for any reason in the past 6 months? This includes excused as well as unexcused absences.)
- EQ-R administered to caregivers, question 3a (How often was he/she usually absent in the past 6 months? This includes excused as well as unexcused absences.)

Outcome 5: A unified, family driven, youth guided, and culturally and linguistically competent system of care for children with SED and their families

- YSS-F administered to caregivers, question 1 (Overall, I am satisfied with the services my child received.)
- YSS-F administered to caregivers, question 2 (I helped to choose my child's services.)
- YSS-F administered to caregivers, question 10 and 11 (My family got the help we wanted for my child; My family got as much help as we needed for my child.)

- YSS-F administered to caregivers, question 12 (Staff treated me with respect.)
- YSS administered to youth, question 1 (Overall, I am satisfied with the services I received.)
- YSS, national evaluation instrument administered to youth, question 2 (I helped to choose my services.)
- YSS administered to youth, question 10 and 11 (I got the help I wanted; I got as much help as I needed.)
- YSS administered to youth, question 12 (Staff treated me with respect.)

Use of the data collected for the national evaluation is demonstrated in the following findings, which were part of a recent assessment done by Impact stakeholders of progress toward one of the key outcomes:

Outcome 1: Maximized functioning of children with SED and their families. The indicator is the level of functioning such that behavioral and emotional problems are reduced and strengths are improved.

- Fifty-two percent of caregivers reported that they strongly agree or agree that their child is better at handling daily life as a result of the services their child and/or family received.
- Fifty-six percent of youth reported that they strongly agree or agree that they are better at handling daily life as a result of the services they received.
- The majority of youth (61 percent) agree or strongly agree that they are satisfied with their family life right now as a result of the services they received.
- Twenty-eight percent of caregivers agree that they are satisfied with their family life right now as a result of the services their child and/or family received; 20 percent are undecided on this measure; the majority of caregivers (52 percent) disagree or strongly disagree that they are satisfied with their family life right now as a result of the services their child and/or family received.

Additional local data are also used to measure key outcomes. For example, Impact measures functioning (key outcome one) with the Child and Adolescent Functional Assessment Scale (CAFAS). A recent finding is that among Impact cases closed between October 2007 and April 2008, 72 percent of youth served by the system of care have a clinically meaningful reduction in their CAFAS score at case closing.¹

Methodology for Retrieving and Presenting Local Data from the National Evaluation

Presenting: Craig Wiles

Impact stakeholders want to track changes over time in the outcome indicators to assess the progress of the system of care and to make adjustments that will increase the effectiveness of key strategies. With that purpose in mind, a data analysis and presentation methodology was designed to provide the stakeholders with the progress of individuals over time. The methodology was designed to retrieve the local data that is collected and submitted to the national evaluation, isolate individual cases for selected variables, and present the findings to the stakeholders so that they can easily track progress as the data is aggregated over time.

The following steps comprise the methodology:

- The community collects and submits data for those caregivers and children willing to participate in the national evaluation at intake, and subsequently, every six months up to 36 months. The national evaluation processes community and aggregate data files nightly,

¹ Impact Evaluation Team. (August 13, 2008). Continuous Quality Improvement Report. Lansing, Mich.: Public Sector Consultants Inc.

also generating scale scores and Reliable Change Index scores. The national evaluation provides a Data Profile Report (DPR) to each system of care site twice a year, and a national aggregate DPR three times a year. Communities can download their own current data files from the ICN (Interactive Collaborative Network) at any time; these data files contain data for each instrument, plus scored outcome variables and constructed variables, in SPSS format.

- Once downloaded from the aggregate files, the selected variables are isolated in SPSS using the SAVE AS function. Using the “variables” tab, only the variables selected by the Impact evaluation team are included for export and then pasted as syntax for use again in the future. Because the data file is static (meaning the variable names in the file will not change during the evaluation), this is pasted as syntax for efficient retrieval of future updated versions of the data file.
- Summary descriptive statistics are run first for each variable and each iteration of the questionnaire. The percentage of all cases is plotted for each of the 5-point Likert responses (strongly agree, agree, undecided, disagree, strongly disagree). This aggregate level analysis provides the starting point for examining the progress of all cases across time (e.g., six months, 12 months, and 18 months)
- The data is then recoded from a five-point scale to a dichotomous value; those who say they strongly agree or agree receive a value of one, and those who say undecided, disagree or strongly disagree are given a value of zero. These two values are then plotted in a diagram (see Figure 1), allowing for case-level analysis of progress across time. For example, all of the cases that were recoded as a zero at six months (an undecided or negative statement of progress) can be plotted again at 12 months to examine relative progress. The diagram presents the data in a manner that facilitates stakeholder review of the effectiveness of the system of care over time.

In this example (Figure 1), 29 caregivers (58 percent) indicated at the six-month interview that they were undecided, disagreed, or strongly disagreed that their child was better at handling daily life. Of this group of caregivers who reported a negative response, and were again interviewed at 12 months, 62 percent now agreed or strongly agreed that their child was better at handling daily life. At the same time, 42 percent of the caregivers indicated a positive response (agreed or strongly

agreed) at the six month interview. Of this group of caregivers who were interviewed at 12 months, a majority (56 percent) again reported a positive response.

While this approach is limited by the fact that not all respondents are in both iterations of the interview (hence, the lower *N* at 12 months), it is expected that as more responses are received across time for each interview, the data will become increasingly valid. In the meantime, the data is being analyzed, updated, and presented to the stakeholder groups so it can become part of monitoring case-level progress. Using this approach, the stage is now set for analyses that will lead to deeper understanding of how families progress over time.

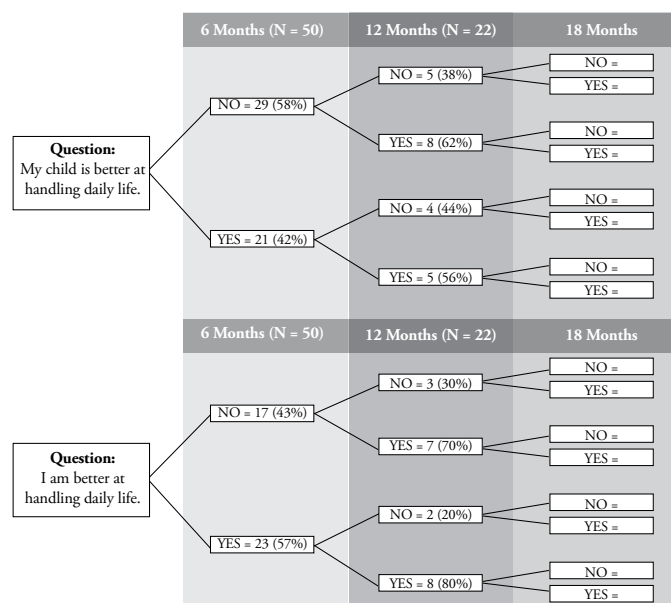
National Evaluation Support to Help Communities Maximize Use of the Data

Presenting: Kurt Moore

As noted above, the national evaluation collects a very large amount of data on children and families receiving services within CMHI-funded systems of care. These data are stored in multiple files in the Interactive Collaborative Network (ICN) System, where they are automatically processed every night. Data from all communities funded in 2005 and 2006, for multiple time points, are collected in an aggregate data file. As Impact demonstrates, funded communities can download files on their own participating youth and families (but may not access information from other communities). This element of the symposium will:

1. Share comparative data analyses on the same indicators of Impact's community-defined outcomes, as presented in the symposium. This allows a comparison between the Impact data and the aggregate national data (Impact data will be removed from the aggregate dataset to prevent any non-independence of the two groups). Factors that may contribute to differences, and implications for the local system of care, will be discussed. Impact stakeholders frequently ask how the local system of care outcomes compare with those of other communities. Comparing local and aggregate national data is one approach that can help address that question, stimulating dialogue and increased understanding of the unique challenges and opportunities for a local system of care.
2. Describe other efforts by the national evaluation to provide communities with useful data analyses, including regular Data Profile Reports and Continuous Quality Improvement Reports. Aggregate Data Profile Reports for CMHI communities funded in 2005 and 2006 are produced three times a year. Site-specific reports are produced twice a year, commencing when communities have data for at least ten children. These reports are provided in PowerPoint format, so that they can be easily presented to different constituents and adapted for local needs. The Continuous Quality Improvement (CQI) Progress Report is generated and disseminated three times per year for communities with sufficient national evaluation data. The CQI Progress Report provides specific data on performance indicators encompassing the key principles of the Comprehensive Mental Health Services for Children and Their Families Program. The CQI Progress Report is organized into five Key Areas of Performance: (1) System Level Outcomes; (2) Child and Family Outcomes; (3) Satisfaction with Services; (4) Family and Youth Involvement; and (5) Cultural and Linguistic Competency. This performance management tool helps communities and program partners to identify specific TA needs, too.

Figure 1
Progress at the Case Level by Interview Time Intervals



SOURCE: Interactive Collaborative Network, Data Profile Report Aggregate Data File, April 2008.
analysis prepared by Public Sector Consultants Inc.
Note: 18-month data are forthcoming.

Monday, March 2 » 1:30 pm

Special Session A Room 11	Cultural Competency: What is “Mental Health” in Indigenous, Island, and Immigrant Populations? <i>Jennifer Dewey, Freda Brashears, Ranilo Laygo & Bonnie Brandt</i>	Page 65
Session 8 Salon A-B	Symposium—Parent Support: Emerging Empirical Evidence – Part 1 <i>Chair: Krista Kutash</i> <i>Discussant: Barbara J. Burns</i> Psychoeducational Psychotherapy: A Collaborative Family-Clinician Model of Care <i>Mary A. Fristad</i> An Empirical Investigation of a Parent Support Program: Parent Connectors <i>Albert J. Duchnowski & Krista Kutash</i>	Page 66
Session 9 Salon C	Symposium—Framing Systems Change: Relating the Parts to the Whole <i>Chair: Sharon Hodges</i> Introduction <i>Mario Hernandez</i> The Value of Systems Thinking in Complex Community Change <i>Pennie Foster-Fishman</i> Systems of Care and the Interactive Systems Framework for Dissemination and Implementation <i>Abraham H. Wandersman & Brigitte Manteuffel</i> Factors in System of Care Development <i>Sharon Hodges</i>	Page 68
Session 10 Salon D	Symposium—Implementing Mental Health Care Interventions with Vulnerable Youth in their Natural Surroundings <i>Chair: William Bannon, Jr.</i> The Association Between Youth Group Participation and Reduced Youth Behavioral Difficulties <i>William Bannon, Jr.</i> STEP-UP: A Youth-Centered, Family-Linked, Community and School-Based Alternative Mental Health Intervention Program for At-Risk Inner City Youth <i>Stacey Alicea</i> Preliminary Qualitative Findings Reflecting Staff Successes and Challenges in Implementing the Clinic Plus Program <i>Mary Cavaleri</i>	Page 69
Session 11 Salon G	Symposium—Early Childhood Systems of Care: Perspectives from Three Federally Funded Sites <i>Chair: Melissa Whitson</i> <i>Discussant: Sylvia Fisher</i> Characteristics of Children Presenting to Early Childhood Mental Health Systems of Care <i>Cindy A. Crusto</i> Risk Factors and Change in 6-Month Outcomes for Children Receiving Services within Early Childhood Systems of Care <i>Joy S. Kaufman & Melissa Whitson</i> Translating Research into Practice: Strategies for Implementing a Public Health Approach to Early Childhood Mental Health <i>Ilene R. Berson</i>	Page 73

Session 12 Symposium—Transition to Adulthood: Services and Natural Supports Associated Page 76
Salon H with Success

Chair: Hewitt B. “Rusty” Clark

Discussant: Nancy Koroloff

Young Adults’ Perspectives on Social Support during Transition to Postsecondary Work / Education

Sarah Taylor

Transition to Adulthood Roles: Young Adults’ Perspectives on Factors Contributing to Success

Nicole Deschênes

Improving Transition Outcomes: Evaluation of Needs, Service Utilization, and Progress/ Outcome Indicators

Karyn L. Dresser & Peter Zucker

Session 13 Symposium—Successful Juvenile Justice Diversion: Impact on the Youth’s Page 80
Salon I Functioning, Recidivism and System Costs

Chair: Kay Hodges

Diversion and Family Based Services Reduce Cost and Entry into Adjudicated Juvenile Justice

Cynthia Smith & Robert Heimbuch

Pre to Post Outcomes for Youth Served by a Juvenile Justice Diversion Program

Kay Hodges

Youth Assistance Program Prevents Progression Through the Juvenile Justice System

Cynthia Williams

Beacon of Light: A Parent’s Perspective on the Impact of Diversion

Dorindia Sheppard & Shyanne Depriest

Session 14 Symposium—Beyond Didactics: Emerging Evidence on EBP Implementation Page 84
Salon J Strategies in New York State

Chair: Kimberly Hoagwood

Initial Findings and Implications of the Evidence-Based Training Dissemination Center (EBTDC)

Alissa Gleacher

Disseminating Evidence-Based Treatments for Children: A Microanalysis of Consultation Calls as an Ongoing Training Strategy

Sandra Pimentel

A Family Support Service Model for Implementing Evidence-Based CBT in Real-World Settings

James Rodriguez

Transporting Evidence-Based Practice to School Settings: Examining Strategies for Consultation

Jessica Mass Levitt

Special Session A » 1:30 - 2:30 pm » Room 11

Cultural Competency:

What is “Mental Health” in Indigenous, Island, and Immigrant Populations?

Presenting: Jennifer Dewey, Freda Brashears, Ranilo Laygo & Bonnie Brandt

Introduction

The notion that one's culture affects the expression, experience, and treatment of mental illness has been reflected in research literature (Atkinson et al., 1993) and public policy for over a decade (USDHHS, 1999, 2001). Discussions have focused on differences between minority populations and mainstream Western culture along dimensions such as the importance of individual achievement versus group cohesiveness, assertiveness versus deference, the role of family and religion, the concept of time, the relationship between the individual and the environment, and policy issues such as disparities in mental health cost or utilization rates.

Discussion has expanded to include the relationship between one's worldview and historical events with three cultural factors: (1) individual culture, (2) culture of service providers, and (3) culture in which the person is seeking help. Recent studies have examined these factors with immigrants in regions with a different majority culture, indigenous peoples, populations experiencing colonization, and refugees (APA, 2005; David & Okazaki, 2006; Mui & Kang, 2006; Nguyen, 2008; Ringold et al., 2005; Twaddle et al., 2002/2003). In operationalizing the term “cultural competence,” Hernandez et al. (2006) conducted an exhaustive literature review of current mental health research related to cultural competency. Their findings suggest that understanding the socio-historical factors affecting diverse cultural groups, their unique cultural characteristics, and a population's unique experience and relationship with mental health providers is critical to improving access, utilization and service satisfaction.

Given the complexity of multiculturalism, providing culturally competent mental health services is a challenge (Aisenberg, 2008; Brashears et al., 2003). However, there remains a call and professional responsibility to meet this need (New Freedom Commission on Mental Health, 2003), particularly within systems of care where cultural competence is a guiding principle.

Staff from the national evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program and participants for system of care sites will provide a context for this discussion, facilitate a group mapping process during which participants will identify indigenous, island, and immigrant population within their communities and share their experiences in serving culturally diverse youth and families. Facilitated discussion will enhance participants' understanding of the role of historical events, immigration, cross-cultural tensions, acculturation, differences in world view, and cultural beliefs related to mental health and explore what is needed to address global service populations.

Issues to be Discussed

The following questions will guide the discussion and be available for participants to take back to their communities for further reflection:

- What culturally diverse populations are within your community? What are their unique experiences/worldviews?
- How do these groups view mental health and mental illness? How are these concepts related to spiritual beliefs?
- Are there socio-historical and cultural factors that impact a population's comfort or willingness to access/utilize mental health services?
- What acceptable, appropriate, and effective treatments can be used with various concepts of mental health/mental illness? How does a service provider factor these concepts into treatment?
- To what extent are the evidence based practices within your community appropriate for use with diverse populations with regard to the specific populations on which they have been normed?

- What demographic and outcome data on diverse populations would be appropriate and useful to collect locally?
- What does “culturally competent” mean in the context of systems of care? How can communities respond to the diversity found within their communities?

Who Should Attend

This session is open to attendance by anyone involved with the Comprehensive Community Mental Health Services for Children and Their Families Program interested in this topic, and others. This includes program and evaluation staff, program partners, and other affiliated parties.

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Session 8 » 1:30 - 3:00 pm » Salon A-B

Symposium

Parent Support: Emerging Empirical Evidence – Part 1

Chair: Krista Kutash

Discussant: Barbara J. Burns

Currently, there is an increased interest in providing empirical evidence for programs that provide support to parents and caregivers of children with emotional disturbances. While advocacy for family support programs is extensive, the empirical support remains sparse. Demonstrating the effectiveness of parent support is crucial in order to inform policy makers and funders about the role of these programs in improving outcomes for children who have emotional disturbances. In this symposium, several models of parent support programs will be presented along with emerging empirical evidence of their effectiveness. Discussants will provide the family perspective and implications for future research will be presented.

In this first symposium, two approaches to family support will be described. First, the research surrounding the Psychoeducational Psychotherapy (PEP) approach to providing social support, information, and skill building to children and families will be presented. This will be followed by the research on the Parent Connectors program, an approach to support families of older adolescents with serious emotional disturbances served in special education settings. The first symposium will conclude with a commentary from a discussant who is a family member and active member of a family advocacy organization.

Psychoeducational Psychotherapy: A Collaborative Family-Clinician Model of Care

Presenting: Mary A. Fristad

Psychoeducational psychotherapy (PEP) is a collaborative therapeutic modality designed to provide social support, information and skill building to children and families (Fristad et al, 1996). It was originally developed to meet the needs of children with major mood disorders. At the time PEP was developed, very limited research was available for youth with these conditions (Fristad, Gavazzi & Soldano, 1998). Some research had been conducted with depressed adolescents, but there were no clinical trials of psychosocial interventions for children aged 12 and under with clinical depression (i.e., major depressive disorder, dysthymic disorder) and there were no clinical trials whatsoever of adjunctive psychosocial interventions for children or adolescents with bipolar disorder.

Early development of PEP included open-label and small randomized clinical trials (RCTs). Three intervention formats were developed: (1) a one-session 90 minute workshop for parents of inpatients, designed to provide basic information to better understand their child's condition (Fristad, Arnett & Gavazzi, 1998); (2) a multi-family psychoeducational psychotherapy (MF-PEP) group format—initially, this consisted of six 75-minute sessions, after the first RCT, $N = 35$ (Fristad, Goldberg-Arnold & Gavazzi, 2002; Fristad, Gavazzi & Mackinaw-Koons, 2003), clinician and consumer input was utilized to expand the intervention to eight 90-minute sessions; and (3) an individual-family psychoeducational psychotherapy (IF-PEP) format (initially, this consisted of 16 50-minute sessions, after the first RCT, $N = 20$, [Fristad, 2006], this was similarly expanded to 20-24 50-minute sessions) (Leffler, Fristad & Klaus, in submission).

MF-PEP has been tested in a large RCT, $N = 165$; results indicate children aged 8-12 with major mood disorders demonstrate reduced mood symptom severity immediately following treatment with improvement continuing throughout 12 additional months of follow-up

(Fristad et al, in submission). Improving family attitudes toward mood disorders leads to seeking improved care which, in turn, leads to improved outcome (Mendenhall, Fristad & Early, in press). Medication utilization changes following participation in MF-PEP, with more families receiving a mid-range of prescriptions rather than zero to one or six or more medications (Cummings & Fristad, 2007).

Although it is encouraging that an RCT demonstrated efficacy, PEP will only be useful if effectiveness trials demonstrate efficacy in community settings. A pilot effectiveness trial is underway, and preliminary data are available (MacPherson, Fristad & Danner, 2008).

In addition to determining whether PEP translates well from an academic medical center into the community, it will be important to determine whether the framework of PEP, which focuses on empowering parents and children by: (1) teaching them about the child's condition and its multi-modal treatment; (2) providing support; and (3) providing skills in symptom management can transfer to other mental health conditions. In that vein, we are also preparing to pilot our work with children with high functioning autism and Asperger's disorder.

This presentation will present highlights from the topics summarized above, and will include a description of the collaborative format of PEP (Fristad, Davidson & Leffler, 2007; Fristad, Gavazzi & Soldano, 1999; Fristad & Sisson, 2004; Goldberg-Arnold, Fristad & Gavazzi, 1999; Mackinaw-Koons & Fristad, 2004).

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An Empirical Investigation of a Parent Support Program: Parent Connectors

Presenting: Albert J. Duchnowski & Krista Kutash

Introduction

While much progress has been made in providing access to special education programs for children who have disabilities, the outcomes of these programs have been disappointing. To help improve educational outcomes there is a critical need to develop strategies to increase the effective involvement of families in the education of their children, especially for children who have disabilities. The outcomes for children who have emotional disturbances continue to be the poorest compared to those for children with other types of disability as well as for peers without disabilities (Wagner, Kutash, Duchnowski, & Epstein, 2005). The importance of these issues is further heightened by the observation that the education of students who have emotional disturbances is considered to be one of the greatest challenges facing the public schools today (Adelman & Taylor, 2000) and it is estimated that 20% of the children in the United States have a diagnosable emotional disturbance (Burns, Hoagwood, & Mrazek, 1999).

This presentation describes the development, implementation, and evaluation of a program providing parental support to families with children identified as having emotional disturbances (ED) and educated in special education programs in public schools. The goal of the project is to improve outcomes for children and their families through parent participation in an effective, school-based parent-to-parent support program which links, through telephone calls, experienced "Parent Connectors" (who have a child that receives services) with parents who have a child with ED. The project is being implemented through a unique partnership of teachers, a family advocacy group, and researchers who have collaboratively constructed a format for conducting a parent support program that can be consistently implemented and evaluated in terms of adherence to the conceptual model.

Methodology

This is a random controlled trial evaluating the effectiveness of a support program for parents of children with ED who are educated in separate Special Education Centers, the most restrictive public school setting. Parents who have a child with ED and who have experienced some success in navigating the system were trained to become Parent Connectors. They deliver support to parents in the study through weekly telephone calls. Parents were randomly assigned to the Parent Connector Group ($n = 60$) or the Teacher Only Group ($n = 55$). In the "Teacher Group," the comparison condition, parents and students interact with teachers who have received training and resources to increase parent involvement in the education of their children. In the "Parent Connector Group," the experimental condition, direct parent support is supplied through telephone calls in addition to the specially trained teacher. Mental health services for children were provided through counselors at the school.

The participants in this project include the parents of children with ED ($N = 115$) and their children. The students ($N = 115$) were primarily male (76%), Black (55%), and 14.6 years of age. The majority of students displayed severe emotional and behavioral difficulties. Parents reported an average of 4.5 people living in the household including the target child and a median income of \$25,200. Nearly half (44%) of families were living below the 2004 poverty thresholds.

Parents were interviewed twice over the course of one school year: once in the beginning of the school year and again at the end of the school year. Parents were interviewed about their own well being (levels of parent stress, hopefulness, empowerment and services efficacy) as well as the functioning of their child (emotional functioning, levels of impairment). School records were reviewed to capture school attendance and discipline referral information and the youth themselves were given academic achievement tests at the beginning and end of the school year. School mental health counselors recorded the type of amount of mental health services delivered to the youth and family members during the school year.

Findings

Parent Connectors reported making an average of 54 phone calls and offered 4.2 hours of individualized support to each of their assigned parents over the nine-month course of the study. The topics most discussed include issues dealing with family life and school.

When examining the outcomes variables, several areas of improvement were noted for families receiving Parent Connector services. For those parents who were highly stressed and lacked confidence in advocating for services for their children, these two areas showed significant improvement over time as compared to the parents in the comparison condition. There was also a trend for parents who lacked a feeling of empowerment to improve over time as compared to the parents in the comparison condition. Youth whose parents received Parent Connector services received significantly more mental health services than youth in the comparison condition and their reading levels were maintained over time whereas the reading condition for youth in the comparison condition declined.

Conclusion

In conclusion, preliminary analyses of the data collected from the project show that a telephone support project for the families of students with emotional disturbances is not only feasible but can be successful in improving the outcomes of these families. Improvements in both caregiver well being and the academic performance of children were noted.

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Session 9 » 1:30 - 3:00 pm » Salon C

Symposium

Framing Systems Change: Relating the Parts to the Whole

Chair: Sharon Hodges

Achieving community based system change is challenged by a need for frameworks that capture the complexity of these multi-level, multi-sector initiatives. This symposium will explore tools that system planners and implementers can use to put system change into practice. Presentations will focus on holistic approaches to system implementation that include frameworks for: (1) articulating clear implementation strategies; (2) understanding the system parts and interdependencies that can help leverage systems change; (3) and understanding the key systems, functions, and relationships relevant to the dissemination and implementation. The session will also present research findings related to successful system implementation.

Introductory Comments

Presenting: Mario Hernandez

The field of children's mental health field, as viewed through the lens of systems of care, needs ways to conceptualize and support system development in the service of quality system change within communities. Better conceptualization of system development and system change supports the creation of a research agenda that will contribute understanding regarding how communities bring about successful transformation as well as the associated underlying mechanisms for change. An important avenue to conceptualize change and how it occurs is to learn from successful communities. In this manner, community innovations can inform research in order to bridge the large practice to research gap. This symposium will present new approaches to bridging the research to practice gap in children's mental health. By building clarity at both ends of the knowledge discovery spectrum, that is, spanning both practice and research, the field of children's mental health can develop useful conceptual frameworks that support system implementation and contribute to the study of local systems of care.

The Value of Systems Thinking in Complex Community Change

Presenting: Pennie Foster-Fishman

In recent years, the need for transformative shifts in our neighborhoods, communities, educational, and service delivery systems has become a call to action for many funders, academics, and change agents. While numerous efforts aimed at promoting significant social change have been pursued, few have achieved what was needed or promised. While there are many explanations for why these initiatives have struggled, this presentation will focus on how a systems thinking

framework can improve the design, implementation, and efficacy of transformative change efforts. Particular attention will be given to the value of this framework to efforts that target change within human service delivery systems, such as system of care efforts.

Systems of Care and the Interactive Systems Framework for Dissemination and Implementation

Presenting: Abraham H. Wandersman & Brigitte Manteuffel

Contributing: Freda Brashears

Systems of care are complex systems with multiple ambitious goals that can benefit from practice based evidence developed by the community and from evidence-based practices developed by researchers. There is a need for new frameworks that use knowledge from *research to practice* models and from evolving *community-centered* models. In this presentation, we discuss the Interactive Systems Framework for Dissemination and Implementation (ISF) that uses aspects of research to practice models and of community-centered models. The framework presents three systems: the Prevention Synthesis and Translation System (which distills information about innovations and translates it into user-friendly formats); the Prevention Support System (which provides training, technical assistance or other support to users in the field); and the Prevention Delivery System (which implements innovations in the world of practice). The framework is intended to be used by different types of stakeholders (e.g., funders, practitioners, researchers) who can use it to see prevention not only through the lens of their own needs and perspectives, but also as a way to better understand the needs of other stakeholders and systems. Applications for using the ISF with systems of care will be discussed.

Factors in System of Care Development

Presenting: Sharon Hodges

What factors contribute to the development of local systems of care? Are there certain processes or mechanisms that are fundamental the system of care implementation? This presentation will present cross-site findings of a 5-year national study of system of care implementation. Strategies that communities undertake in implementing community-based systems of care will be discussed. In addition, how certain implementation factors support opportunities to create change in local service systems for children with serious emotional disturbance and their families will be discussed.

Implementing Mental Health Care Interventions with Vulnerable Youth in their Natural Surroundings

Chair: William Bannon, Jr.

Contributing Authors: Mary McKay & Kimberley Hoagwood

This symposium is designed to illustrate the benefits of engaging vulnerable youth in programs designed to treat their mental health needs in their natural settings. Accordingly, we will examine innovative early intervention and treatment programs designed to operate in the child's natural environment. Such interventions are believed to help improve school performance, social relationships, and prevent mental health, economic, and social problems in adulthood. We present preliminary outcome data, as well as discuss how issues related to mental health care stigma and other barriers related to lack of engagement in care, may be circumvented through providing services universally to youth in their home and school settings. Scientific research supports the premise that with effective treatment, children can, and do, recover quickly from emotional challenges. However, problems related to the identification of mental health need among children and barriers to engagement often prevent children from getting needed mental health care and making a recovery. This symposium aims to contribute to the field of child mental health care through describing how services may be delivered to children in their natural surroundings in a way that effectively supports children with mental health need.

The Association Between Youth Group Participation and Reduced Youth Behavioral Difficulties

Presenting: William Bannon, Jr.

Introduction

Conduct Disorder (CD) and Oppositional Defiant Disorder (ODD), are often identified as the most frequently diagnosed disorders of childhood and adolescence, accounting for 1/3 to 1/2 of all youth mental health referrals (Knock, Kazdin, Hirripi, & Kessler, 2006). The behaviors that are associated with these diagnoses are broad, yet are regularly associated with sexual risk-taking, substance abuse, and delinquent behaviors. Studies have suggested that youth behavioral outcomes may be enhanced through involvement in youth groups (Kerestes, Youniss, & Metz, 2004; Youniss, McLellan, Su, & Yates, 1999; Youniss, McLellan, & Mazer, 2001). The current study examines youth group participation as a possible factor protective of youth behavioral difficulties.

Research question: Will youth who participated in youth groups be less likely to engage in sexual risk taking, substance abuse, and delinquent behaviors?

Method

Study Sample and Settings

All data were taken from the National Longitudinal Study of Adolescent Health (Harris et al., 2003). The study is one of the nation's largest and most rigorous studies of adolescent behavior. The current study utilizes the public-use dataset for Wave I, which consists of one-half of the core sample, chosen at random. The total number of respondents in the public-use dataset in Wave I is 6,504. Of these youth, 52% are female ($n = 3356$) and 48% are male ($n = 3147$). The average child is approximately 16 years old ($SD = 1.62$).

Measures: Outcomes

Delinquent behaviors. Youth reported if they had taken part in 15 delinquent behaviors over the past 12 months.

Sexual risk-taking. Sexual risk-taking was examined through a single item where youth were asked if they ever had sex.

Substance abuse. Youth reported data concerning their use of cigarette, alcohol, and various illegal drugs over their lifetime.

Joint occurrences. Youth reported if they over the past 12 months they had been drinking alcohol when using drugs, been driving while drunk or high on drugs, and been drunk or high on drugs while at school.

Independent variables

Participation in youth groups. Youth indicate if they attended youth groups weekly, infrequently (< once per month), or never, over the past 12 months.

Covariates

The following variables were controlled for in the current analysis:

- **Demographics.** Data on basic child demographics (race, age, and sex) and family SES (has the residential father or mother of the youth received public assistance over the past 12 months – yes/no) were collected and controlled for in these analyses.
- **School problems.** The current research also measured and controlled for the presence of school problems through 2 items: (1) has youth ever repeated a grade – yes/no; and (2) has youth ever received an out of school suspension – yes/no.
- **Youth mental health state.** Youth mental health state was measured with a 19-item scale included in the ADD Health study.
- **Exposure to community violence.** Exposure to community violence was measured with an 8-item scale included in the ADD Health study.
- **Protective factors.** Protective factors were measured with an 8-item scale included in the ADD Health study.

Data analysis

Logistic regression was used to examine the association between youth group participation and behavioral outcomes, while controlling for various other behavioral difficulty risk factors.

Findings

The data indicate that youth group participation is protective of youth behavioral difficulties in several domains, while controlling for key youth demographic, protective, and risk factors. First, in regards to delinquent behaviors, Table 1 describes that over the past 12 months, in reference to youth that participated in youth groups weekly, youth that never attended youth groups were more likely to have shoplifted, used drugs, and stolen something worth less than \$50. Second, in regard to sexual risk taking behavior, Table 2 describes that in reference to youth that participated in youth groups weekly, youth that attended youth groups infrequently and never attended youth groups were more likely to have had sex. Third, in regard to substance abuse, Table 3 describes that in reference to youth that participated in youth groups weekly, youth that attended youth groups infrequently and never attended youth groups were significantly more likely to have smoked a cigarette, smoked regularly, have had a drink of beer, wine, or liquor more than two or three times in their lifetime, and to have used marijuana in their lifetime.

There was also evidence of youth who never attended youth groups to be more likely to have used cocaine and other illegal drugs in comparison to youth who attended youth groups weekly. Finally, Table 4 presents that among youth who reported using drugs, those who never attended youth groups were significantly more likely to drink alcohol when using drugs, to drive while high on drugs, and to have gone to school while high on drugs in comparison to youth who attended youth groups weekly over the past 12 months.

Conclusion

There is evidence that youth group participation is protective of various types of delinquent behaviors, sexual risk-taking, and substance abuse, as well as the combining of these behaviors. These findings may offer preliminary evidence supporting the implementation of youth groups as a tool to enhance youth behavioral outcomes.

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Table 1
Delinquent Behavior Stratified By Youth Group Attendance
Over The Past 12 Months (Only Significant Results Among The 15 Items Contained On The Scale Are Reported)

Rate of youth group Attendance past 12 mo	No n (%)	Yes n (%)	B (SE)	Wald	P	OR (CI)
1) Shoplifted						
Weekly (Reference)	1145 (82%)	254 (18%)				
Infrequently	1390 (78%)	391 (22%)	.16 (.10)	2.79	.10	1.2 (.97-1.41)
Never	1829 (76%)	573 (24%)	.19 (.09)	4.12	.04	1.2 (1.01-1.43)
2) Used drugs						
Weekly (Reference)	1335 (96%)	63 (4%)				
Infrequently	1685 (95%)	95 (5%)	.01 (.18)	.00	.96	1.0 (.71-1.43)
Never	2197 (91%)	209 (9%)	.36 (.16)	4.99	.03	1.4 (1.05-1.98)
3) Stolen something worth <\$50						
Weekly (Reference)	1195 (86%)	203 (14%)				
Infrequently	1469 (82%)	313 (18%)	.15 (.10)	2.13	.14	1.2 (.95-1.42)
Never	1932 (80%)	473 (20%)	.21 (.10)	4.63	.03	1.2 (1.02-1.50)

Table 2
Sexual Risk-Taking Behavior Stratified By Youth Group Attendance Over the Past 12 Months

Rate of youth group Attendance past 12 mo	No n (%)	Yes n (%)	B (SE)	Wald	P	OR (CI)
1) Ever had sex						
Weekly (Reference)	1003 (72%)	388 (28%)				
Infrequently	1078 (61%)	695 (39%)	.44 (.09)	24.02	.000	1.6 (1.30-1.86)
Never	1317 (55%)	1075 (45%)	.53 (.09)	38.3	.000	1.7 (1.44-2.02)

Table 3
Substance Abuse Stratified By Youth Group Attendance Over the Past 12 Months

Rate of youth group Attendance past 12 mo	No n (%)	Yes n (%)	B (SE)	Wald	P	OR (CI)
1) Ever smoked a cigarette						
Weekly (Reference)	761 (55%)	635 (45%)				
Infrequently	823 (46%)	967 (54%)	.18 (.08)	5.71	.02	1.2 (1.03-1.40)
Never	967 (40%)	1441 (60%)	.33 (.07)	19.39	.000	1.4 (1.19-1.60)
2) Ever smoked regularly, that is, at least one cigarette every day for 30 days (only includes youth that report having smoked, n=2728)						
Weekly (Reference)	223 (52%)	207 (48%)				
Infrequently	291 (41%)	412 (59%)	.32 (.13)	6.05	.01	1.4 (1.07-1.76)
Never	426 (37%)	722 (63%)	.41 (.12)	11.76	.001	1.5 (1.19-1.92)
3) Had a drink of beer, wine, or liquor more than two or three times in their life						
Weekly (Reference)	833 (60%)	563 (40%)				
Infrequently	782 (44%)	999 (56%)	.52 (.08)	43.76	.000	1.7 (1.44-1.96)
Never	927 (39%)	1478 (62%)	.62 (.08)	67.84	.000	1.9 (1.61-2.16)
4) Used marijuana in their lifetime						
Weekly (Reference)	1177 (85%)	212 (15%)				
Infrequently	1338 (79%)	436 (21%)	.20 (.10)	3.88	.05	1.3 (1.00-1.50)
Never	1605 (67%)	784 (33%)	.73 (.10)	57.84	.000	2.1 (1.71-2.49)
5) Used cocaine in their lifetime						
Weekly (Reference)	1368 (98%)	22 (2%)				
Infrequently	1731 (97%)	44 (3%)	.15 (.28)	.31	.58	1.2 (.68-2.00)
Never	2288 (96%)	98 (4%)	.44 (.25)	2.99	.08	1.5 (.94-2.53)
6) Other illegal drugs in their lifetime						
Weekly (Reference)	1341 (97%)	48 (3%)				
Infrequently	1681 (95%)	93 (5%)	.22 (.19)	1.31	.25	1.2 (.86-1.81)
Never	2139 (90%)	245 (10%)	.73 (.17)	17.62	.000	2.1 (1.47-2.90)

Table 4
Joint Occurrences Of Substance Abuse Stratified By Youth Group Attendance Over the Past 12 Months

Rate of youth group Attendance past 12 mo	No n (%)	Yes n (%)	B (SE)	Wald	P	OR (CI)
1) Drinking alcohol when using drugs (only includes youth who reported having used alcohol and drugs)						
Weekly (Reference)	142 (67%)	69 (33%)				
Infrequently	243 (65%)	134 (35%)	.07 (.19)	.13	.72	1.1 (.74-1.56)
Never	395 (54%)	341 (46%)	.38 (.18)	4.63	.03	1.5 (1.03-2.06)
2) Driving while high on drugs (only includes youth that report having used drugs)						
Weekly (Reference)	222 (87%)	34 (13%)				
Infrequently	334 (79%)	88 (21%)	.38 (.24)	2.61	.11	1.5 (.92-2.33)
Never	615 (74%)	220 (26%)	.46 (.22)	4.48	.035	1.6 (1.03-2.42)
3) Being high on drugs while at school (only includes youth that report having used drugs)						
Weekly (Reference)	194 (76%)	62 (24%)				
Infrequently	291 (69%)	131 (31%)	.28 (.19)	2.23	.14	1.3 (.92-1.93)
Never	511 (61%)	324 (39%)	.49 (.17)	7.87	.005	1.6 (1.16-2.28)

STEP-UP: A Youth-Centered, Family-Linked, Community and School-Based Alternative Mental Health Intervention Program for At-Risk Inner City Youth

Presenting: Stacey Alicea

Introduction

Increasing numbers of urban adolescents of color are experiencing complex mental health difficulties, and frequently evidence health compromising risk taking behaviors. More specifically, urban African American and Latino youth are much more likely to grow up in disadvantaged neighborhoods characterized by high levels of stressors, along with deteriorating youth-supportive resources, including a serious shortage of mental health services. Many aspects of these disadvantaged contexts have the potential to thwart successful youth development. An overlapping set of behaviors, such as sexual risk taking and substance use can further serve to compromise youth mental health through the development of a substance abuse disorder or exposure to HIV infection. In addition, even though portions of the child mental health service delivery system may exist within inner-city community contexts, these clinics are not always effectively integrated with existing community structures and resources, and are frequently avoided by teens who could gain substantial benefit from mental health care. In sum, adolescents of color who evidence serious mental health needs and risk taking behaviors without linkage to mental health care during this critical developmental juncture may be already on an extremely negative trajectory just prior to the transition to early adulthood.

Project Step-Up aims to develop, pilot and evaluate an alternative youth-centered, family-linked and community/school-based mental health intervention, which draws upon existing aspects of three evidence-based interventions funded by the National Institute of Mental Health: (1) Multiple Family Groups (McKay et al., 2002); (2) SUUBI (Ssewamala, 2005) and; (3) CHAMP Family Program (McKay et al., 2000; Madison, McKay et al., 2000). Step-Up is therefore informed by: (1) social action theory; (2) asset theory, specifically the incentives and reinforcements associated with accumulation of resources that serve as the foundation of adulthood; (3) theories guiding youth community level involvement and civic participation; and (4) family focused intervention models.

The proposed project represents both an attempt to intervene with youth evidencing complex mental health needs and impairments across inner-city ecological domains and an effort to intervene at multiple levels (school, family and community) in order to address mental health difficulties, specifically conduct problems.

Methodology

Project Step-Up is a one year pilot intervention embedded in 2 high schools in East Harlem and Bronx, New York. Forty-six adolescents, ages 14 to 17, with serious impairments in behavioral and educational functioning (i.e. at least one school year behind in required high school coursework) due to complex and unmet mental health difficulties, specifically conduct problems, were referred to Step-Up by school guidance counselors and staff. Students and parents were given information about the program and parents were asked to provide consent for their child's participation. Fifty-five percent of enrolled youth identified as Hispanic/Latino and the remaining 43% as Black. Sixty-one percent of enrolled youth reside in single parent households.

Youth groups meet each week for 2 hours and study groups meet 2 times per week for up to 2 hours during the school year. Youth groups

utilize a life skills curriculum with a strong focus on youth development (i.e. life, future planning, pride, problem solving skills, etc.). In the summer, youth can obtain internships through Step-Up, find jobs and/or enter summer school to obtain missing credits. In addition to youth groups, each adolescent has a one-on-one mental health specialist that provides guidance, support, and when necessary referrals to individualized or family mental health treatment, and a youth specialist that provides mentorship. Youth can earn incentives by participating in group sessions, consistent and on-time attendance, and working toward the attainment of their future goals. Key family members are also involved in a series of home and school-based multiple family group meetings with parent advocates. Lastly, crisis intervention is available when needed.

The program is currently seeking funding for a rigorous evaluation of the impact of the intervention on youth risk behavior and mental health, impairment and functioning across inner-city ecological contexts. Preliminary school level data related to behavior, collected at program start and again at a 4-month mid-evaluation, will be presented along with case study examples.

Findings

Table 1 presents statistics on average number of absences, tardiness incidences, final term GPA, number of core classes passed, and number of suspensions by term for all Project Step-Up participants. For all participants between Term 1 and Term 2, there is an overall decrease in the average number of absences, tardiness incidences, and suspensions. Moreover, between Term 1 and Term 2, there was an overall increase in the final term GPA and number of core classes passed. For all Project Step-Up participants, there was a general improvement in academic and behavioral performance during the time that participants were actively involved in the Step-Up program. Further data will be incorporated into a preliminary analysis as it becomes available.

Table 1
Descriptive statistics for all Project Step-Up participants

	<i>Average # of Absences</i>	<i>Average # of tardy incidences</i>	<i>Final GPA%</i>	<i># of Core Classes passed</i>	<i># of suspensions</i>
Term 1	7.05	25.45	66.48	3.78	1.90
Term 2	6.48	21.55	67.54	3.90	0.20

Conclusion

Project Step-Up represents an integration of existing theory-driven, evidence-based interventions at a critical developmental juncture. This multi-level, multi-component alternative mental health intervention is designed to engage at-risk youth, families and schools and deliver or connect them to services that work to reduce problem behaviors and disorders as well as enhance their academic success. At every level, the collaborative model used has been able to successfully engage a range of partners in working toward a common goal. Overall, Project Step-Up focuses on mental health service delivery and prevention and on the need for intervention to occur in a developmentally appropriate manner. Next steps will include a rigorous evaluation of the program and its various components to determine its effectiveness and level of impact.

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Preliminary Qualitative Findings Reflecting Staff Successes and Challenges in Implementing the Clinic Plus Program

Presenting: Mary Cavaleri

In 2006, Governor Pataki proposed the largest annual investment in child mental health in New York State history; \$62 million for the New York State Office of Mental Health (NYSOMH) to implement an initiative titled *Achieving the Promise for New York's Children and Families. Child and Family Clinic Plus*, for which \$33 million was allotted, arose out of this initiative.

Clinic Plus was a response to alarming rates of unmet need among youth with mental health difficulties. Indeed, although there are an estimated 17 to 26% of youths in need of mental health care across the United States (Brandenburg et al., 1987; McCabe et al., 1999), a concerning number of such youth do not receive any mental health services. As a case in point, community-based mental health programs often report "no-show" rates for first time intake appointments exceeding 50% (Lerman & Pottick, 1995), while Kazdin (1996) estimates that between one-half to three-fourths of children with mental health needs either do not engage in treatment or drop out of care prematurely.

Accordingly, *Clinic Plus* was initiated to transform the child mental health system via the provision of universal screenings in the child's naturalistic settings, comprehensive assessments, and evidence-based treatments in a variety of settings (particularly in the family home) to ensure that interventions work in the child's natural surroundings (NYSOMH, 2008).

This symposium presents results of an examination of *Clinic Plus*; specifically, to better understand the processes and results associated with enrolling and engaging families into *Clinic Plus* as well as the provision of screenings, assessments, and treatment to youth and their families. More specifically, this project examines (1) processes related to the enrollment, consenting, screening, assessment, and treatment of youth at clinic sites, including challenges and successes associated with these components, and (2) changes in agency practice and service delivery, including new linkages and agreements with other organizations and the adoption and provision of evidence-based and in-home treatment services since becoming a *Clinic Plus* provider.

Methodology

The evaluation is a multi-stage project which includes both New York State licensed mental health provider agencies and caregivers of youth which could potentially be served by this initiative. In order to fulfill the above-noted aims, a sample of ten *Clinic Plus* provider agencies were involved in the proposed implementation study across all five New York State regions. Five provider agencies across the state were selected by the New York State Office of Mental Health based upon

OMH staff perception of advanced capabilities and strengths related to implementation of *Clinic Plus*. An additional five provider agencies from the remaining clinics on the approved list of *Clinic Plus* providers were randomly selected and approached to be involved in the study. From each provider agency, at least two to three clinical staff members, a clinical supervisor and an administrator, participated in a focus group in order to explore their experiences with *Clinic Plus*, including any areas of strength as well as difficulties in implementation. This existing data is supplemented by the completion of standardized questionnaires which were based upon input from New York Office of Mental Health staff regarding core concepts and issues regarding the *Clinic-Plus* initiative.

Additionally, up to 100 staff representing *Clinic Plus* sites who were participating in the learning collaboratives conducted by Dr. Mary McKay (collaborative multi-agency consortiums which encourage successful strategies to facilitate caregiver engagement in *Clinic Plus*) completed a separate questionnaire which assesses efforts to improve enrollment and service provision and successes and challenges related to such.

Findings

The data was still being collected and analyzed at the time of submission. However, we anticipate that data will reflect the successes and challenges of implementing a revolutionary initiative designed to reform the child mental health system across New York State, and give a detailed description regarding the process of engaging and treating youth with mental health needs and their families.

Conclusions

The proposed study is in concordance with a long-term initiative set by New York State to transform the child mental health service system by facilitating the early detection of and treatment for mental health difficulties among youth. However, the implications of this study reach beyond this initiative given such high rates of unmet need among youth with mental health difficulties; thus it is of great import to understand the factors that impact the implementation of initiatives such as *Clinic Plus*, which introduce new incentives, opportunities and knowledge in a large state child mental health system, as the ultimate goal of this initiative is to enhance access, utilization of child mental health care and youth mental health outcomes.

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Early Childhood Systems of Care: Perspectives from Three Federally Funded Sites

Chair: Melissa Whitson

Discussant: Sylvia Fisher

Systems of care for children with severe emotional and behavioral difficulties have traditionally focused on a school-aged population. However, early childhood is a critical period for the onset of emotional and behavioral impairments. According to the National Center for Children in Poverty (NCCP), between 4 and 6 percent of preschoolers have serious emotional and/or behavioral disorders. Research suggests that intervening when emotional and behavioral difficulties begin to emerge significantly impacts the effectiveness of an intervention, as well as the cost. In response to these and similar findings, a number of early childhood systems of care have recently begun to be supported. The purpose of this symposium is to present findings from three federally funded early childhood systems of care. The first presentation provides information about the young children and families being served, including child and family characteristics, and relevant risk and protective factors that are present within these populations. The second presentation expands on the first by examining the influence of pertinent risk factors on child outcomes six months after entry into the system of care. The final presentation challenges us to examine social-emotional difficulties in young children from a public health perspective.

Characteristics of Children Presenting to Early Childhood Mental Health Systems of Care

Presenting: Cindy A. Crusto

Contributing: Meghan Finley, Ilene R. Berson, Maria J. Garcia-Casella, Joy S. Kaufman, Amy Griffin & Melissa Whitson

Introduction

Early childhood mental health systems of care develop services and supports to promote positive mental health, prevent mental health problems, and provide mental health interventions for children, aged birth to six years, and their families. With a few notable exceptions, SAMHSA children's mental health systems of care communities have primarily addressed the mental health challenges of older children and youths and their families. A growing number of early childhood mental health systems of care are being supported, yet little is known across communities about the demographic and background characteristics of these children or their experiences that may have and continue to place them at risk for or protect them from psychiatric difficulties. This presentation pools data from three different federally (SAMHSA) funded early childhood systems of care communities to:

- understand who are the young children aged birth to six years and their families served,
- report on factors that may have increased children's risk for social, emotional, and/or behavioral challenges or protected them from these difficulties, and
- report on children's exposure to potentially traumatic events.

Methodology

Data were collected from 299 children ages 0.3 to 6.00 ($M=4.02$ years) and their families. There were 216 (72%) boys and 83 (28%) girls. The racial distribution of the children was as follows: 199 (67%) were Caucasian, 56 (19%) were African American/Black, 31 (10%) were of other racial backgrounds, 1 (0.3%) was American Indian/Alaskan Native, and 12 (4%) were missing. Fifty (17%) of the children were of Latino/Hispanic ethnic background.

Children and their families were seeking participation in three SAMHSA-funded system of care communities (two in the Northeast and one in the Southern United States), focusing on building mental health systems of care for an early childhood population. As required by the federally mandated national cross-sectional study, the Enrollment, Demographic, and Information Form (EDIF), a 28-item measure, was used to collect information from all families seeking services. Service providers, such as care coordinators or clinicians collected the information from the child's caregiver upon presentation to the system of care for services. The Traumatic Events Screening Inventory-Parent Report Revised- (TESI-PRR; Ghosh-Ippen, et al., 2002) is a 24-item semi-structured interview that determines a history of exposure to traumatic events in children six years and younger. Caregivers are presented with a list of traumatic events and asked if the child has ever experienced them and if the child has experienced them in the past six months using three response categories: "yes," "no," "unsure." In addition, parents report on the age at which the child first experienced the trauma and the age of the child when the most stressful occurrence of each potentially traumatic event was experienced.

Findings

The problems for which the young children were most frequently referred to the systems of care were difficulties with adjustment (28%), school performance (12%), and other problems (40%). With respect to psychiatric diagnoses, the most frequent DSM-IV diagnoses were disruptive/conduct behavioral disorders (24%), and adjustment disorders (23%), followed by various types of ADHD (13%). Less frequent diagnoses were anxiety disorders (10%), posttraumatic stress disorder (7%), pervasive developmental disorders (5%), mood disorders (5%), disorders of infancy and early childhood (4%), and reactive attachment disorders (2%). For communities using the Diagnostic Classification of Mental Disorders of Infancy and early Childhood, Revised edition (DC:0-3R), adjustment disorders were the most common Axis I disorders. The quality of the parent-infant relationship was rated for 30 children and they experienced perturbed (1%), significantly perturbed (2%), distressed (4%), disturbed (2%), and disordered (1%) relationships. Anxious-tense primarily categorized parent-child relationships.

With respect to the major referral sources, children were referred to the mental health systems of care by their caregivers in just over one-third (34%) of the cases, followed by school (15%), mental health agencies/providers (14%), other sources (14%), child welfare (7%) and physical health care agency/provider (7%). Over one-third (41%) of the children were involved with a mental health agency and 19% were involved with a school.

TESI data were provided for 164 children. Thirty-eight percent of these children experienced separation from a caregiver, while the children also reported being exposed to: physical assault of someone else (32%); threatening physical assault within in the family (24%); an illness of someone close to the child (23%); arrest, jail, or imprisonment of a family member (25%); serious medical procedure or life threatening illness (23%); community violence (11%); neglect (13%); and other, non-specified stressful events (32%).

Conclusion

Given the previous call and need for trauma-informed systems of care and services, it is imperative that the potentially traumatic experiences of young children presenting to systems of care are systematically assessed and addressed in the context of services and supports. The types

of potentially traumatic events that are being assessed by these early childhood mental health systems of care extend the assessment beyond a few salient events to 24 different types of events. This will deepen our understanding of which types of potentially traumatic events and how trauma histories and ongoing trauma experiences impact mental health functioning in young children.

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Risk Factors and Change in 6-Month Outcomes for Children Receiving Services within Early Childhood Systems of Care

Presenting: Joy S. Kaufman & Melissa Whitson

Contributing: Ilene R. Berson, Maria J. Garcia-Casellas, Cindy A. Crusto, Meghan Finley & Amy Griffin

Introduction

In recent years a number of systems of care have focused on young children with severe emotional and behavioral challenges, however, little is known about risk factors that may predict outcomes for these children. Data was pooled from three SAMHSA funded system of care communities with the goal of examining these predictors.

Systems of care for children with severe emotional and behavioral difficulties have traditionally served a school-aged population (Manteuffel, Stephens & Santiago, 2002). There is clear evidence that intervening when emotional and behavioral difficulties begin to emerge makes a significant difference in both the cost of an intervention and its probable success (Strain & Timm, 2001; Kazdin, 1995). Research has shown that early childhood services that include home visiting and parenting education result in parents who are able to be more emotionally supportive and have more positive interactions with their children (Love, et al., 2002). However, the literature regarding the risk factors that put young children at risk for severe emotional and behavioral challenges is still limited.

Methodology

The cohort funded by SAMHSA's Comprehensive Community Services for Children and their Families Program in 2004 includes seven communities whose work focuses on an early childhood population. Since the National Evaluation for the system of care communities is geared toward a school age population, many of the early childhood communities began work to identify measures appropriate for younger children. The data presented in this paper has been gathered from three of the early childhood system of care communities (Connecticut, Florida, and Rhode Island).

The children enrolled in these systems of care are on average 4.02 years of age, predominately boys (72%), and with regard to race/ethnicity, 67% Caucasian, 19% African American/Black, 10% "Other," and 0.3% American Indian/Alaskan Native. About 17% of the population served to date is Hispanic/Latino. A third (34%) of the families are self-referred and the most frequent diagnoses include disruptive/conduct behavioral disorders (24%), adjustment disorders (23%), and various types of ADHD (13%). For the present outcome analyses, the sample included only children who were enrolled in the longitudinal outcome study ($n = 135$). For this sample of 135 children, the demographic information reflects a similar pattern to the larger sample. On the TESI-PRR, the caregivers of these children reported that the children had been exposed to a mean of 3.2 traumatic events, ranging from 0 to 13.

Measures

The measures included in these analyses represent a subset of those collected as part of the evaluations at these sites.

Risk Factors. Risk factors include the number of traumatic events tabulated from the Traumatic Events Screening Inventory-Parent Report-Revised (TESI-PRR; Ghosh-Ippen, et al., 2002) and a measure of maternal depression (Center for Epidemiology Depression Scale; CES-D; Radloff, 1977).

Child Outcomes. Child Outcomes include internalizing problem behaviors and externalizing problem behaviors (Child Behavior Checklist for Ages 1.5-5; CBCL; Achenbach & Rescorla, 2000), in which higher scores reflect more problem behaviors. Additionally, social emotional strengths and challenging behaviors were measured with the Devereux Early Childhood Assessment – Clinical Scale (DECA-C) Total Protective Factors T Score (LeBuffe & Naglieri, 1999), with higher scores reflecting more emotional strength and resilience.

Findings

A multivariate multiple regression examined the relationship between several risk factors and child outcome variables at intake. In order to account for missing data, the AMOS 17.0 statistical package, which employs Full Information Maximum Likelihood (FIML) estimation, was used. Risk factors included the sum of the number of traumatic events from the TESI-PRR and the maternal depression clinical score from the CES-D. Outcome variables that were included were the CBCL internalizing and externalizing T scores and the DECA Total Protective Factors T score. Results of the analysis revealed that the number of traumatic events a child had experienced was positively and significantly related to two of the three outcomes variables at intake. Specifically, the number of traumatic events was related to internalizing problem behaviors ($\beta = .18, p < .05$) and emotional strengths ($\beta = .35, p < .001$). Similarly, maternal depression was significantly positively related to internalizing behaviors ($\beta = .18, p < .05$). Conversely, maternal depression was negatively related to emotional strengths ($\beta = -.19, p < .05$). Externalizing problem behaviors was not significantly related to either number of traumatic events ($\beta = .09, ns$) or maternal depression ($\beta = .15, ns$).

A paired samples t-test was conducted to examine change in the outcome variables from intake to the 6-month follow-up. Results of this analyses revealed that CBCL internalizing scores significantly decreased from intake into system of care services ($M = 65.77, SD = 8.92$) to six months following service entry [$M = 62.33, SD = 10.72, t(56) = 3.30, p < .01$]. CBCL externalizing scores also significantly decreased from intake ($M = 71.98, SD = 12.90$) to six months later [$M = 64.63, SD = 12.76, t(56) = 4.72, p < .001$]. Finally, the change in DECA Total T scores, measuring a child's emotional strength, from intake ($M = 38.63, SD = 10.69$) to six months later ($M = 41.48, SD = 10.66$) approached significance, $t(59) = -1.88, p = .065$.

Conclusions

This presentation highlights some predictors of social emotional health for young children who are exhibiting severe emotional and behavioral problems. The results demonstrate that children whose mothers report higher levels of depression demonstrate higher levels of internalizing problems and lower levels of emotional strength. This finding further demonstrates the need to work with all members of a family, one of the core philosophies of systems of care. These data also highlight the significant impact that trauma exposure has on a young child's functioning. Higher levels of internalizing problems were seen for children who had experienced more traumatic events. However, higher numbers of traumatic events were also related to higher levels of emotional strength. This result could suggest that those children

who have had to deal with more trauma have demonstrated resilience as they have built up their emotional strengths perhaps to better cope with this trauma. Finally, the results also indicate a significant reduction in symptoms just six months after the children were enrolled in the systems of care. While these results are preliminary, they suggest that young children who receive services from early childhood systems of care experience an improvement in functioning. These are promising results for early childhood systems of care and highlight areas for future research.

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Translating Research into Practice: Strategies for Implementing a Public Health Approach to Early Childhood Mental Health

Ilene R. Berson

Understanding Early Childhood

A public health approach to early childhood mental health emphasizes the promotion, preservation, and restoration of young children's socio-emotional well being. This presentation will translate the findings from the early childhood systems of care into practice strategies that reflect a comprehensive, systematic, public health approach to improving the mental health status of young children. The discussion will highlight the importance of a complementary focus on strengthening protective factors and promoting resilience to help reduce the negative outcomes of current and future risk exposure.

The findings of the early childhood system of care research presented as part of this symposium suggest that trauma exposure and protective

factors can be used to identify children at imminent risk for emotional and behavioral problems. Trauma is a significant predictor of internalizing and externalizing behavior problems, and resilience moderates the effect of trauma exposure on symptomatology. The combination of high risk-status and inadequate protective factors compound to intensify the detrimental effect on a child's functioning and emotional well being. The results highlight the relevance of risk and resilience to early childhood mental health. Our research findings suggest that the field of early childhood mental health would be enhanced by a resilience-informed approach to understanding home, school, and community factors that protect children from the adverse effects of traumatic experiences. Preventive intervention should focus on strengthening protective factors and promoting resilience, which may reduce the negative outcomes of current and future risk exposure.

Early childhood is a critical period for the onset of emotional and behavioral impairments. According to the National Center for Children in Poverty (NCCP), between 4 and 6 percent of preschoolers have serious emotional and/or behavioral disorders. Without early identification from screenings, assessment, and effective intervention these problems may escalate, and untreated mental health disorders can interfere with young children's functioning and future outcomes.

Early childhood mental health is influenced not only by the physical characteristics of the young child, but also the quality of the adult relationships in the child's life, the caregiving environments the child is in, and the community context in which the child and family lives. Although it has been hypothesized that changes in parenting predict changes in disruptive behaviors among young children, recent findings have suggested that proactive and positive parenting only has a moderate mediating effect on reducing the risk for conduct disorders among preschoolers (Gardner, Shaw, Dishion, Burton, & Supplee, 2007). Conversely, frequent disruptions in family life and high parental distress are associated with persistence in socio-emotional and behavioral problems of young children (Briggs-Gowan, Carter, & Bosson-Heenan, 2006). This study indicates that early childhood mental health problems are not transient, but rather they persist as children age.

Early childhood mental health is defined across three domains: experiencing, regulating, and expressing emotions; forming close, secure relationships; and exploring the environment and learning. Young children rely on their parents and other primary caregivers to figure out how to manage the full range of their emotions, and to feel safe and confident enough to explore their environment. This is how they learn. This is why parents and primary caregivers are so very important in early childhood. In early childhood settings, a child who is not secure in relating to others, doesn't trust adults, is not motivated to learn, or who cannot calm themselves, or be calmed enough to tune into teaching will not benefit from early educational experiences. In fact, more and more young children are being expelled from child care and preschool for behavior problems (Gilliam, 2005).

Public Health Strategies

This paper introduces public health strategies such as cumulative risk screening that may help focus preventive intervention where it will be most efficient and effective (e.g. based on number of risk factors experienced, occurring after risk exposure and before development of problems, in the context of service resources, etc.). Appropriate screening tools can be used to identify children and get them into the services they need to prevent young children from developing more severe and persistent disorders. Moreover, since children are impacted greatly by adult risk behaviors (i.e., mental illness, drug abuse, criminal activity), a complementary focus on strengthening protective factors and promoting resilience within the family may help reduce the negative outcomes of

current and future risk exposure. Screening and comprehensive service delivery are part of a public health approach for promoting, preserving, and restoring young children's mental health. The approach focuses on both strengthening services and supports for children with serious emotional disorders and their families, and on prevention and early intervention strategies for all children. To achieve this public health approach, cross-system partnerships are needed within communities to implement and sustain such services.

The Early Childhood Community of Practice Diagnosis and Eligibility Workgroup has been exploring implications for a public health approach as a result of discussions that took place at the Early Childhood Pre-Conference meeting in New Orleans, July 2007. The workgroup developed a draft Concept Paper that was presented to the Early Childhood Community of Practice participants at the Training Institutes in July, 2008 in Nashville. Suggestions from the workgroup serve as exemplars of public health strategies that promote, prevent, and restore well being for young children at imminent risk for developing a mental health or serious emotional disorder.

1. This workgroup recommended that the eligibility for enrollment in SAMHSA Systems of Care Cooperative Agreements include not just those infants and young children with a diagnosed mental health disorder, but also infants and young children who are judged to be "at imminent risk" for developing a mental health or serious emotional disorder.
2. Infants and young children judged to be at "imminent risk" for developing a mental health or serious emotional disorder must meet the criteria identified in a screening tool that assesses risk and resilience for early childhood mental health. Identification or development of appropriate tools should be the focus of ongoing research—OR—The young child must be diagnosed with a DC: 0-3R Axis II Relationship Disorder and a PIRGAS Score of 40 or

below indicating a Relationship Disorder in the "Disturbed" category. For eligibility purposes, this disorder could be recorded as an ICD-9-CM Axis I Diagnosis of 313.3 Relationship Disorder (parent/child).

3. It was also recommended that an infant or young child identified at "imminent risk" be closely observed, monitored, and assessed for development of a possible DC: 0-3R or DSM-IV Axis I mental health disorder, and referred for a comprehensive mental health assessment should symptoms worsen.
4. Further, it was recommended that infants and young children identified at "imminent risk" receive appropriate developmental assessments and mental health interventions, in collaboration with other early childhood intervention services, to assist in remediation of emotional or behavioral symptoms that could lead to a mental health or serious emotional disorder.
5. Ongoing research should explore additional risk factors, such as family history and environmental conditions that may place a child at "imminent risk" of developing a mental health disorder or serious emotional disturbance.

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Session 12 » 1:30 - 3:00 pm » Salon H

Symposium

Transition to Adulthood: Services and Natural Supports Associated with Success

Chair: Hewitt B. "Rusty" Clark

Discussant: Nancy Koroloff

The purpose of this symposium is to provide new findings on services and natural social support factors that are associated with progress and outcomes of transition-age youth and young adults with emotional/behavioral disturbances (EBD). These studies describe qualitative and quantitative findings that provide indications of the types of services and natural social supports that contribute to the success of young people. The first study is a qualitative study with young adults that examined their perspective on social supports and the extent to which these may be facilitative factors. The second presentation is also a qualitative study of young adults who, based on objective criteria, were considered "successful." Study findings yielded a pattern of factors associated improved progress and outcomes across various transition domains. The third study in this symposium series is a program evaluation of a developing transition system serving youth and young adults with EBD. This study provides qualitative and quantitative results suggesting an association between services received and progress indicators for these young people. These studies point to the importance of developmentally-appropriate services—and emphasize the essential role that natural supports play in the lives of these transition-age young people. The discussant, presenters, and audience members will discuss the implications of these findings for designing and enhancing service systems to improve the work, school, and life outcomes of youth and young adults with EBD and their families.

Young Adults' Perspectives on Social Support during Transition to Postsecondary Work / Education

Presenting: Sarah Taylor

Introduction

Young adults who are involved in mental health and other social service systems experience significant challenges in the transition to adulthood, particularly in the areas of education and employment. In this short-term longitudinal study, the researcher met with eleven young adults five times each during a four-month follow-up period as they navigated transitions to school and work. The findings describe four distinct transition pathways and young adults' specific needs for support during these transitions.

Young adults ages 16-25 who are involved in public social service systems such as mental health, child welfare, and juvenile justice are at risk of experiencing significant problems in the transition to adulthood (Osgood, Foster, Flanagan, & Ruth, 2005). An area of concern for these young people is in completing secondary school and/or entering post-secondary education, as well as finding and maintaining stable employment. Data from the National Longitudinal Transition Survey-2 (2005) shows that for young adults with serious mental illnesses, educational and employment difficulties are extremely common. In

young adults who received special education services due emotional disturbance, only 42% of those out of school for at least one year were currently employed. Close to 40% left school for reasons other than graduation, and just 33% attended some type of post-secondary educational program (SRI International, 2005).

Though research documenting the difficulties young adults face is available, few studies describe ways to support youth in making more successful school and work transitions. This qualitative study followed 11 young adults, including 5 with serious mental illness, as they began a new work or school situation. The purpose of the study was to understand the factors that impede or facilitate successful transitions, as they unfold in real time, from the young adults' perspective. This presentation focuses on the social support young adults received, or wished to receive, to help them navigate a work or school transition.

Methods

A purposive sampling strategy was used to recruit 11 young adults ages 18-25 who were imminently beginning a new work or school situation. They were referred by social service agencies and youth-serving non-profits in a large metropolitan area. Participants were tracked over an average of 3.8 months, during which time they participated in 1 screening meeting and 4 semi-structured interviews, thus the dataset includes 5 encounters with each individual, 55 in total. Interview topics included review of transition progress, family characteristics, personal characteristics, and educational and employment history. To triangulate the data and increase validity, the researcher conducted 9 telephone interviews with "someone who knows you well," an individual identified by the participant. Data were collected between March 2006 and February 2007. The conceptual framework for the study was based in the literature on emerging adulthood (Arnett, 2000), life course, and ecosystems theories.

The analysis was guided by Miles and Huberman's (1994) stepwise process for qualitative research. Once index coding was complete, timelines for each participant were developed using post-interview notes and transcript segments coded as "transition activity," "long-term goals," and "short-term goals." Constant comparison (Glaser and Strauss, 1967) was then used to construct the typology of participant experiences described below. The findings on support were developed by using a version of Patton's (1980) process-outcome table, in which the researcher identified supportive actions and associated outcomes for each participant using transcript segments coded as "support," "hindrance," and "wishes." Findings related to support were then compared between young adults as individuals, and as members of the typology groups to see if and how support varied between the groups.

Findings

Participants' experiences of work and school transition were categorized as: *steady progress*, *planned exploration*, *accidental exploration*, and *frustrated aspiration*. Young adults identified three types of support related to their work and school transitions: *tangible*, *teaching and mentoring*, and *developmentally appropriate connection*. The elements of *developmentally appropriate connection* include *availability*, *investment*, *recognition*, *safety*, and *interdependence*.

Young adults who made the most progress (the *steady progress* and *planned exploration* groups) were able to identify more sources of support, and the support provided was stable and varied according to the participants' needs in a given situation. Those who made less progress (*accidental exploration* and *frustrated aspiration*) were able to identify fewer sources of support, and the support was inconsistent and not as tailored to the participants' needs. The social networks described by those who made less progress were also more likely to include professional service

providers, rather than family or friends. Case studies of young adults with serious mental illness whose experiences fit these categories will be highlighted in this presentation. Interestingly, no participants with mental illness in this sample had a transition experience that could be categorized as *planned exploration*.

Implications

Though this research is exploratory, it contributes to the literature on young adults who are involved in mental health and other social service systems by enhancing our understanding of transition from a young adult's perspective. The explication of support for young adults is helpful as a training tool for clinicians working with this population (Clark, Deschênes, Sieler, Green, White, & Sondheimer, 2008). Practitioners are often instructed to "be supportive," but, the concept of *developmentally appropriate connection* as consisting of *availability*, *investment*, *recognition*, *safety*, and *interdependence* clarifies the often vague construct of support.

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Transition to Adulthood Roles: Young Adults' Perspectives on Factors Contributing to Success

Presenting: Nicole Deschênes

Contributing: Joanne Herrygers & Hewitt B. "Rusty" Clark

Introduction

The purpose of this "success" study was to gain a better understanding of the experiences and perspectives of young adults who are considered to have achieved some indicators of success in their transitions to adulthood. This qualitative study addressed the research question, "What factors enable young people with emotional/behavioral disturbances (EBD) to successfully transition to adulthood?"

Methods

In this study, success was defined as a multi-dimensional concept that encompassed factors such as educational achievements, career and employment status, independent living, personal and social relationships, and social-emotional adjustment and functioning. Success was also

defined as movement toward acceptable adult behavior, achievements in relation to society's norms, and developmental state (e.g., improved graduation from regular high school, finding and keeping a job, entering a post-secondary educational program, living on one's own). Participant recruitment was done through project managers and transition facilitators from four Transition to Independence Process (TIP) sites in Florida who were asked to nominate young people who met all of the following qualifications: (a) had a history of EBD; (b) received some transition-to-adulthood services; (c) graduated from high school; and (d) overcame significant challenges to achieve noteworthy accomplishments.

Researchers used the *Success Interview* protocol, a data collection instrument containing open-ended questions to interview nine participants. In accordance with Smith's (1995) funneling technique, whereby the literature and previous analyzed data drove the directions of the questions, the open-ended interviews (Patton, 1990) encouraged the interviewees to describe their real-life experiences to share what they view as effective transition supports and services, and to offer advice. Data from seven interviews were analyzed using Glaser and Strauss' (1967) constant comparison method for the development of grounded theory. Reliability was addressed through inter-rater agreement regarding the interpretation of the data (Miles & Huberman, 1994).

Findings

Qualitative analysis yielded the following patterns of factors associated with successful transitions to adulthood.

Theme 1: Goal Orientation. Most of the participants were future and goal oriented. They had a sense of purpose, a focus, and a direction. All had practical, realistic, attainable aspirations that were very similar to the goals and aspirations of their peers with no disability. Although most young people interviewed seem to realize it may be more difficult for them to achieve their dreams than it would be for youth who do not have EBD, they all seemed ready to do what needs to be done to accomplish what they set out to do in life and were either "confident" to "extremely confident" in their ability to face the future.

Theme 2: Interests and Abilities. Closely related to the capacity to be goal oriented is the ability of successful youth in our sample to recognize and integrate their particular interests and abilities in everything they set out to do. Many of the participants had exposure to school-sponsored work and volunteer projects. In these projects, participants learned job-related skills, refined their cognitive skills, developed support networks, and increased their self-confidence.

Theme 3: Creative Coping Strategies. To adapt to their often-difficult situations, the interviewees found creative strategies, techniques, devices, and other mechanisms to enhance their ability to cope and perform well. One of the most striking characteristics of these successful young people was their capacity to work hard and persist in achieving their goals. Early on, they seemed to have discovered that they would have to work longer and harder than most simply to keep pace with others and do well. Whether in school or on the job, most youth we interviewed were willing to make sacrifices and extend extra efforts demanded by their particular situation in order for them to succeed. A variety of skills building techniques such as reframing or application of anger management techniques were used by most to deal with obstacles encountered on the road to success.

Theme 4: Social Support. All of the participants recognized the need for support and took advantage of the help they could access along the way to overcome hurdles and cope with difficult situations. Most youth established a network of positive and supportive people including family members, relatives, friends, community organizations, teachers, co-workers, transition facilitators and others on whom they

could rely. Everyone had access to support, at some time, through his or her transition program. Support was provided to them in many forms including:

- Emotional support providing a caring and trusted person with whom the youth could share experiences.
- Instrumental support providing tangible aid and services.
- Informational support providing advice, suggestions, and information that youth can use to address difficulties.
- Appraisal support providing information useful for self-evaluation, constructive feedback, affirmation and social comparison.

Researchers observed common elements in the support provided to the participants. Commonalities included commitment, dependability, encouragement, trust, guidance, patience, discipline, confidentiality, and protection.

Theme 5: Role Models. Finally, many of these young people had positive role models who provided encouragement and demonstrated, through their own experiences, how to succeed in the face of challenges. Many participants named role models from within the immediate family, however, some named extended family, teachers and one celebrity. Participants had some connection with the named role model. The primary connection was a familial relationship. Other connections were a perceived shared challenge leading the young person to believe that if their role model could overcome challenge, then he/she young person could do the same.

Implications and Conclusions

The findings from this "success" study yielded a pattern of supports and services that these young adults suggested contributed to their progress and success in transitioning to adulthood roles. The implications for practitioners, educators, program administrators, and policy makers are that programs and policies should support the development of community transition systems that incorporate the following features:

- Incorporate the young person's future focus in transition planning and services.
- Base transition plans on early identification of the youth's abilities and interests.
- Teach creative coping techniques.
- Ensure continuous and consistent social support.
- Encourage young people to identify and learn from role models.

These features are components of the Transition to Independence Process (TIP) model that is now considered an evidence-supported practice (Clark, Deschênes, & Jones, 2000; Clark, Koroloff, Geller, & Sondheimer, 2008).

References

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Improving Transition Outcomes: Evaluation of Needs, Service Utilization, and Progress/ Outcome Indicators

Presenting: Karyn L. Dresser & Peter Zucker

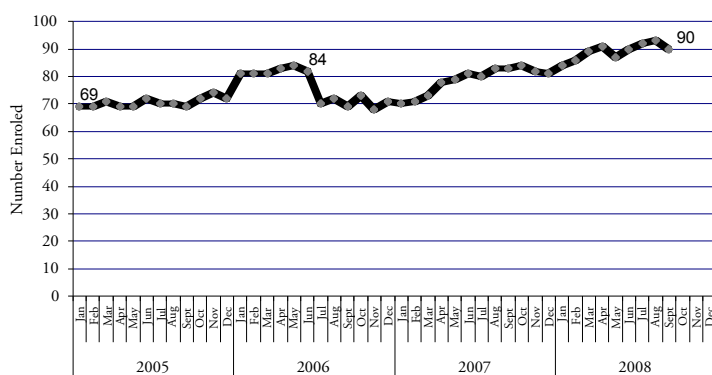
Introduction

This paper addresses the evaluation of the *STARS Community Services (STARS CS) Transitional Age Youth Program (TAYP)* which operates in Alameda County, California. The evaluation provides a quality assurance assessment encompassing demographics, service utilization, and progress/outcome indicators of transition-age youth (TAY) served over the last two years.

The STARS CS TAYP assists clients in their transition to adulthood and community living by providing comprehensive care management including counseling and therapy, medication support, crisis intervention, independent living skills coaching, and transition planning and resource linkage. The TAYP also provides evidence-informed practices for specific treatment needs, such as *Aggression Replacement Training (ART)* (Goldstein, Glick & Gibbs, 1998) with EQUIP (Glick, Potter & Goldstein, 1995) groups, and *Wellness Recovery Action Planning (W.R.A.P.)* (Copeland, 2002) which infuses the entire program with a wellness and recovery orientation, building peer support among clients along with access to professional services.

Service Utilization. The TAYP has been in operation since 1998, serving 86 older youth and young adults per year on average. More recently the average count is 114 TAY per year on average (37 newly enrolled and 34 discharges per year). There were steady capacity increases over the first years, and ups and downs in utilization over the past four years (see Figure 1). The dip in mid-2006 was related to management changes that brought more active oversight to closing out inactive cases. The county has continued to build capacity, increasing the contracted census to help meet service needs.

Figure 1
Stars CS Month End Census



Methods

STARS CS participates in the Stars Behavioral Health Group (SBHG) outcomes program, which uses a number of measurements gathered upon admission, every six months or annually, and at the time of discharge. In this report, the outcome data come from the SBHG Client Outcomes Report (COR) which tracks key indicators across four key domains—safe at home/family-like settings, attending and progressing in school/vocationally, improving in health/mental health, and out of trouble with the law. COR samples were selected to include both discharged clients (with length of service of at least 180 days) and long term active clients (in service for at least two years); each had to have both enrollment and subsequent measurements available, which yielded 38 pairs for study purposes. The data are mostly categorical and presented descriptively. An alpha of $p < .05$ is used for statistical tests including paired samples *t*-tests. These data are applied to continuing quality improvement efforts.

Findings

Client Profile

Regarding the six month period leading up to their enrollment or at the time of enrollment, data on unduplicated clients ($N = 143$) served during the past two program fiscal years (July-June 06-07 & 07-08) show that: (a) youth and young adults were between the ages of 17-24, with a median age of 19; (b) there were far more males (71%) in the sample than females; (c) almost half were African American (43%), followed by Anglo-American (27%), Latino American (18%), and Asian American (10%). Of this group, 57% had a major mental illness (e.g., psychotic, schizophrenic, etc.); 46% had internalizing problems, and 11% had externalizing problems. Almost one-quarter (23%) had a co-occurring substance abuse problem. Aggressive behaviors and substance abuse risk were found in about half of the sample (48% and 53% respectively). Most youth and young adults lived in a community setting (76%), were high school graduates (45%) or had vocational training (36%). Many youth and young adults also received support from family members (85%) or another available adult (95%), although almost one-third (30%) reported having problem relationships as well.

Referrals

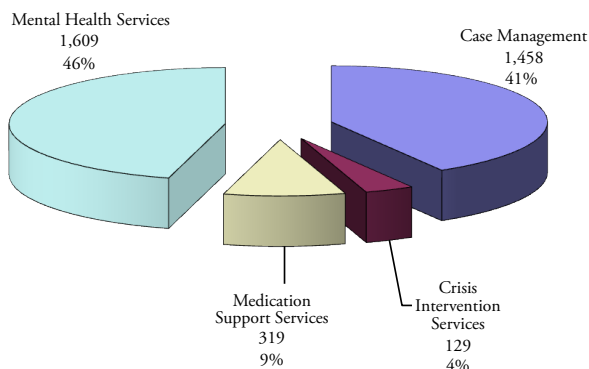
Youth and young adults voluntarily enroll in the TAYP upon referral from psychiatric hospitals (27%); crisis services (15%); child outpatient programs (15%); residential providers (10%); and in equal numbers (6% each) from social services, criminal justice, private practitioners, self/family, or mental health access unit.

During the most recent program year, TAYP older youth and young adults received a total of 415,000 units (minutes) of billed services, which reflects a little over one hour each of service contact each week, on average (varies by client and over time in program). The average amount of service contact is consistent since the last report (FY 05-06; see Figure 2).

Key Findings

Mixed results include gains regarding housing and adult supports, insufficient education/vocation, and persistence of risk behaviors. Key findings for outcomes in transition domains (i.e., living situations, education/vocation, adult supports, and health and functioning), which compare time at admission to at least two years of services (active cases) or discharge, will be discussed and disseminated during the presentation. Implications of those findings are summarized below.

Figure 2
Agerage & Percent of Billed Units
Per TAY in a Year by Service Types
FY 07-08 Data (118 Clients & 415,000 UOS)



Implications

The evaluation results are mixed with some positive signs, particularly regarding living situations—e.g., decreased numbers of TAY in non-secure living situations such as homeless, hotels, or temporary with friends and family, and decreased numbers of problems reported in their living situation—and availability of positive adult supports. On the other hand, there appears to be insufficient movement among at least half of the TAY with respect to education and vocation, and the behavioral risk status of the youth, as reported by their clinicians, are not showing desired reductions over time in services. Some of the agency personnel have been

exposed to the *Transition to Independence Process* (TIP) model, which is an evidence-supported practice. However, to date, STARS CS TAYP has not been through the training and fidelity assessments required in establishing a TIP model site (Clark, Deschenes, & Jones, 2000). The evaluation indicates that reviews of the practices applied to individual and group therapy are warranted with close attention to EBP model adherence and service intensity, careful monitoring of treatment progress, more focused interventions regarding substance abuse, greater consideration of cultural factors in treatment, and use of advanced SBHG clinical consultation. These findings will be applied to specific developmental actions through the agency's continuous quality improvement process.

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Session 13 » 1:30 - 3:00 pm » Salon I

Symposium

Successful Juvenile Justice Diversion: Impact on the Youth's Functioning, Recidivism and System Costs

Chair: Kay Hodges

This session will describe the implementation and evaluation of a youth diversion program, Correct Course, which is administered by the Juvenile Access and Assessment Center (JAC). Youth who successfully complete the diversion program have their charges dismissed, thus avoiding further penetration into juvenile justice. A computerized, self-administered interview, the Juvenile Inventory for Functioning (JIFF; Hodges, 2004), is used to identify the service needs of first-time offenders, match them to community-based services, and collaborate with parents in generating a service plan. The youth are assigned to an appropriate Youth Assistance Program (YAP), whose charge is to meet the youth's needs and provide services. When the youth has completed the program, both the youth and caregivers take the JIFF a second time. Cynthia Smith will describe the program and discuss its impact, including low recidivism rates and dramatic cost savings, which have been used to expand diversion services. Additionally, given that 70% of the sample is African American youths from a large urban area, this program has significantly reduced the overrepresentation of minority youth entering juvenile justice compared to past years. The significant improvements observed in the diverted youths' day-to-day functioning are presented by Kay Hodges. Cynthia Williams from Black Family Development, Inc. (BFDI), one of the 12 YAP programs, will describe the low recidivism rates observed for their program, which includes evidence based treatments. Finally, Dorindia Sheppard from the BFDI program will address the impact the diversion program had on her family and the role of families in these types of initiatives.

Diversion and Family Based Services Reduce Cost and Entry into Adjudicated Juvenile Justice

Presenting: Cynthia Smith & Robert Heimbuch

Contributing: Mary Johnson, Kay Hodges & Lisa Martin

Introduction

Diversion means that youth arrested for a juvenile charge avert entry into the formal justice system through assignment to community based service programs and avoid prosecution and a juvenile record. In this process, youth that are assessed at detention admission or when a legal decision may be made to offer diversion from adjudication, benefit from timely screening, using the Juvenile Inventory for Functioning (JIFF) (Hodges, 2004). The JIFF is a client centered computerized screening tool, which yields an individualized service plan. Where charges result in detention, the JIFF guides the Jurist decisions at the 24 hour Preliminary Hearing regarding continued detainment thus potentially reducing unnecessary detainment costs and providing needed services. Constructive intervention and attention to youth and families at a critical time are proven to work in this model. Immediate attention to family needs identified by the JIFF helps families to maintain the youth safely at home and assure return for subsequent hearings.

Procedure

Subjects

In 2008, the JIFF was administered to two groups of youth: (1) first time offenders with charges dismissed and their caregivers and (2) youth arrested and detained pending Preliminary Hearings. 1,103 detained youth were JIFF screened with JIFF reports to Preliminary Hearing Jurist within 24 hours of arrest. 556 diversion youth and 556 caregivers were evaluated via the JIFF, provided a service plan and immediate services. Demographic characteristics of both groups are given in Tables 1 and 2.

Table 1

Gender of Youth Able to Benefit from JIFF Assessment and Alternative to Detainment

2008 Correct Course Gender			2008 Detention Admission Gender		
Count	Percent		Count	Percent	
Female	206	37%	Female	130	12%
Male	350	63%	Male	973	88%
Total	556	100%	Total	1103	100%

Table 2

Race of Youth Able to Benefit from JIFF Assessment and Alternative to Detainment

2008 Correct Course Youth Race			2008 Detention Youth Race		
Count	Percent		Count	Percent	
African American	350	63.0%	African American	878	79.6%
Arabic-American	8	1.4%	Arab/Chaldean	13	1.2%
Caucasian	184	33.1%	Caucasian	184	16.7%
Hispanic	14	2.5%	Hispanic	24	2.2%
			Other	4	0.36%
Total	556	100.0%	Total	1103	100.0%

Measures and Procedures

Within the one hour process of JIFF screen to JIFF plan, the Juvenile Assessment Center clinicians are able to rapidly triage and assign families to local and useful Youth Assistance (YAP) services. Each youth and family are given a copy of the JIFF report chart and an individualized plan. Each Youth Assistance agency receives a fax to copy that is designed to support six-months of specialized but not high cost services. As needed, access to community mental services is coordinated the same day. The JIFF chart and service plan given to each family guides them regarding goal achievement and managing their own services knowledgeably.

Court procedure and detainment are time consuming, difficult processes when youth with mental health needs are waiting for something helpful to happen. As needed, access to more intensive evaluation and specialized services is provided within the same day.

In detention, the JIFF report coupled with the admission alcohol and other drug urine screen analysis provides the Preliminary Hearing Jurist with factual information for questioning and determination of options. This report guides the jurist regarding options for service resources that can assist the youth and family to address early rehabilitation.

Having the youth and the caregiver complete a JIFF evaluation at diversion allows for the caregiver to have thoughtful input and feel valued for their understanding of their youth. Youth and caregivers both find the JIFF an easy useful process where frustration and anger are set aside as the activity of answering questions takes on a thoughtful process and responses to questions are honest and genuine.

Using the two JIFF reports to develop an individual service plan becomes a fully engaged activity. Each family member feels empowered by their answers and “heard” regarding their feelings and choices as a

service plan is made with them right after the screening interview. JIFF plans help youth and families realize that services are being chosen to fit their needs and wishes. In this process, families often unite to address serious family conflict as they feel encouraged to become more successful together. Caregivers and youth respond with joy and surprise when they compare the initial JIFF to the post JIFF scores. It becomes a celebration of success with visual evidence of achievement and change.

Juvenile Justice youth in Wayne County are from many cultures. Using the JIFF provides opportunity for youth and caregivers to give their own thoughts and to know that their perceptions create the JIFF report and plan. This honors culture and values a diverse population.

Analysis

The recidivism analysis for Correct Course youth currently provides evidence that less than 3% of the diversion youth are convicted of new offenses post service completion. These youth and families are benefiting from early access to much needed services. Reduced detainment is cost effective and benefits youth by not being contained with more serious juvenile offenders and reduces potential for learning more negative juvenile behaviors by proximity. Cost analysis provided below (see Table 3) shows that the cost savings per youth receiving release or diversion is between \$9,000 and \$22,000. The value of an ability to offer youth diversion, screening and access to mental health services, substance abuse services, local community supports and resources at an initial contact point with the juvenile justice system is augmented by the cost analysis and recidivism data.

Table 3

Outcome of Cost Analysis and Potential Savings to System

Cost Analysis (not including Court and Detainment Costs)	
Cost Per Youth in Youth Assistance Program 6 months	\$1,031
Cost Per Youth in Intensive Juvenile Justice Services Community 6 months (1)	\$9,100
Cost Per Youth in Residential Care Juvenile Justice 6 months (2)	\$3,310
Cost Per Youth of Detainment average 45 days to adjudication and release to services (3)	\$26,010
Cost Savings Per Youth that be diverted or released from detention with knowledge based decision making and useful resource assignment	between \$9,000 and \$22,000 per youth receiving release and/or diversion

1 average cost of 6 months community probation \$50 per day

2 average cost for 6 months residential care \$205 per day

3 cost of detainment average of 45 days

Conclusions

The data on the population's benefiting from the JIFF screen and access to Correct Course diversion programs and an alternative to detainment using the JIFF caregiver and JIFF youth assessment impacts greatly on system cost, detainment cost and disproportionate minority representation in a large metropolitan area that experiences high poverty rates, great diversity and economic stressors.

This screening and access to service works and is cost effective. Both youth and caretakers enjoy the process, experience and results. Caregivers have shown staff how they keep the JIFF report with them to remind them of important goals. The bar chart of the JIFF report gives visual clarity of significant problems and functional areas of strength and success.

For Fiscal 2008, Wayne County Detention populations were greatly impacted by attention to early assessment and resources in the community and diversion. As a result of diversion and early detention

release, two alternative detention facilities with capacity of 58 beds were able to be closed. 2008 probation adjudications alone were reduced by 32.6% over 2007 numbers. Cost analysis shows savings of 53.1% below 2007 fiscal year for Wayne County Juvenile Justice probation costs. Funding for this service is shared by Wayne County Children and Family Services and Detroit Wayne Community Mental Health.

References

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- Detroit Wayne County Community Mental Health, *Juvenile Assessment Center Diagnostic and Assessment Contract*, Veda Sharp, Director, Carrie Banks-Patterson, Children's Services.

Pre to Post Outcomes for Youth Served by a Juvenile Justice Diversion Program

Presenting: Kay Hodges

Contributing: Lisa Martin, Cynthia Smith & Mary Johnson

Introduction

The “cross system” needs of youths accessing services via the juvenile justice system are well documented. The Juvenile Access and Assessment Center (JAC) receives juvenile justice intakes and is the point of access for services for adjudicated juveniles in Detroit-Wayne County. A new diversion program (Correct Course) was developed in which the prosecutors’ office refers the youth and family to JAC staff and receives recommendations for enrollment as an alternative to prosecution. The information garnered from a screening tool, the JIFF, provides the basis for agreeing to alternative services, determining the need for more critical and intensive services, and selecting a service type to more specifically meet the needs of each youth and family. Youths are then assigned to a Youth Assistance Program (YAP) which is a community partner contracted to meet the service needs of the youths. Upon completion of the YAP program, the youth takes the JIFF interview a second time. This paper presents the outcome data available to date on the youth who have completed Correct Course diversion program.

Method

Subjects

The JIFF is being administered to two groups of youths: first-time offenders who are petitioned for an array of offenses but not-in-custody (NIC), and youth who are in detention pending preliminary hearings. To date the JIFF has been administered on 2048 youths, 728 NIC youth and 1175 detained youth (147 youth’s custody status was undetermined). There are five classes of charges, class 1 charges include truancy to class 5 which includes felony charges. The frequencies of each charge class are class 1 (174), class 2 (47), class 3 (383), class 4 (731) and class 5 (375). The ages of the youths ranged from 8 to 20 years ($M = 14.97$ years), with 76.2% of the sample being male. The sample was 70.6% African American, 22.4% Caucasian, 3.7% Hispanic, and 3.3% Other.

To date, 308 of the NIC youth, and 276 caregivers of these youth, have completed pre and post JIFF interviews (i.e., before and after participating in diversion, which generally lasted 4 to 6 months). The demographic characteristics for this sample are comparable to the larger sample. The ages ranged from 9 to 19 years ($M = 14.87$ years), with 68.2% being male. This sub-sample was 69.2% African American, 26.9% Caucasian, 2.3% Hispanic, and 1.6 % Other.

Measures

Juvenile Inventory for Functioning (JIFF). The JIFF (Hodges, 2004) assesses the youth’s day-to-day functioning across 10 domains: School, Picked on by Peers, Non-compliance in the Home, Family Environment (reflects on undesirable behavior by others in the home, not the youth), Unsafe Community Behavior (delinquency), Feelings (depression, anxiety, trauma), Self-Harm, Substance Use, and Health concerns. The JIFF was derived from the Child and Adolescent Functioning Scale (CAFAS; Hodges, 1989), which has strong psychometric evidence. The JIFF consists of a self-guided computerized interview that is available in two formats, one in which youths report about their behavior and the second, in which caregivers answer questions about the youth’s functioning. There is an additional scale, Burden of Care, in the caregiver version. The JIFF interview takes about 20 to 25 minutes to complete. The JIFF software nominates goals based on the respondent’s answers, and the staff then selects goals with the family and matches service recommendations to each goal. The result is a service plan that can be helpful in specifying treatment needs across the continuum of care. The JIFF Service Plan, which is generated in collaboration with parents, is shared with service providers and officers of the court. The JIFF can be administered repeatedly to track outcomes.

Procedures

At the youth’s first court hearing, if the officers of the court and the family agree that the youth is an appropriate candidate for the diversion program, the youth and the caregiver each take the JIFF interview immediately after the hearing. In total this takes about an hour.

Analyses

Pre and post comparisons of the JIFF total score and subscale scores were conducted for the 308 youth and 276 caregivers who participated in the diversion services. Mean differences of each of the subscales were computed and d -statistics were generated to evaluate the magnitude of change.

Results

Table 1 summarizes the findings for change over time for the JIFF total score and subscale scores. The JIFF total score and every subscale score changed significantly ($p < .02$) between the first JIFF (pre-YAP intervention) and the second JIFF (post-YAP intervention) for both youth and caregivers. D -statistics were calculated to evaluate the magnitude of change. Most notable were the large effect sizes found for the JIFF total score (Youth $d = 0.79$, Caregiver $d = 0.77$) and the School subscale (Youth $d = 0.77$, Caregiver $d = 0.79$). Moderate effects sizes were observed for Noncompliance in the Home (Youth $d = 0.56$, Caregiver $d = 0.56$).

Conclusions

The preliminary results are encouraging in that they suggest the diversion program is associated with significant improvement in the youth’s day-to-day functioning, based on independent reports by youth and caregiver. Significant effects were observed for all of the domains, in the direction of improved functioning. Large effect sizes were observed for the total score and for functioning at school, with moderate effects for increased compliance in the home. In the presentation, limitations

Table 1
Outcomes for JIFF Total Score and Subscale Scores

	Youth N = 308			Caregiver N = 276		
	Mean Difference (T1-T2)	(p-value)	D statistic	Mean Difference (T1-T2)	(p-value)	D statistic
Total	6.57	0.000	0.79	9.27	0.000	0.77
School	2.74	0.000	0.77	4.11	0.000	0.79
Picked on by Peers	0.14	0.000	0.23	0.19	0.000	0.32
Noncompliance in Home	0.89	0.000	0.56	1.52	0.000	0.56
Peer Influences	0.11	0.019	0.13	0.36	0.000	0.29
Unsafe Community Behaviors	0.51	0.000	0.39	0.45	0.000	0.37
Feelings	0.61	0.000	0.34	0.76	0.000	0.43
Self Harmful Potential	0.33	0.000	0.27	0.21	0.000	0.23
Substance Use	0.50	0.000	0.39	0.51	0.000	0.35
Health Related Needs	0.29	0.000	0.27	0.26	0.000	0.22
Family Environment	0.50	0.000	0.44	0.75	0.000	0.28
Burden of Care (Caregiver only)				0.32	0.000	0.27

of the study will be discussed (e.g. need for comparison group in future research). As implemented in Detroit, the JIFF screening process has proved to be helpful to the court in identifying the youth's needs (considering both the youth's and caregiver's report), in determining appropriateness for inclusion in the diversion program, and in assessing the program's effectiveness.

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Youth Assistance Program Prevents Progression Through the Juvenile Justice System

Presenting: Cynthia Williams

Contributing: Kenyatta Stephens, Ebony Williams & Tonia Williams

Introduction

The purpose of the Black Family Development, Inc. (BFDI) Youth Assistance "Passport" Program is to prevent at-risk and diversion youth, residing on Detroit's Eastside, from entering or progressing through the Juvenile Justice System. The name, "Passport" was used to depict the adolescent competencies. BFDI's intervention serves to build youth resiliency and protective factors using four (4) tracks or "Ports of Call." The "Ports of Call" included education and culture, entrepreneurialism, individual and family support, and structured recreation.

Youth participated in groups that addressed assessed person risk factors they encountered on a consistent basis, including but not limited to: Anger Management, Substance Abuse Prevention, Domestic Violence, Violence Prevention, Conflict Resolution, and Relationships. In addition to group sessions, youth were also provided support through individual and family counseling sessions with experienced counselors. Youth participated in structured recreational activities, entrepreneurialism, career development, Aggressive Replacement Therapy, substance abuse education, mentoring, homework assistance/tutoring, computer training, arts/drama and cultural awareness activities. This paper presents an overview of the program as well as outcome data available to date.

Program Design

Black Family Development's 2007-2008 Passport Program is family-centered in order to maximize program efficacy on the youth's behalf. The Passport program operates five days per week, and was modeled after two Office of Juvenile Justice and Delinquency Prevention (OJJDP) prevention programs: *Lions Quest: Skills for Adolescence and Aggression Replacement Training*. While being research-driven, BFDI's Passport Program was designed to make prevention services engaging and interesting to youth. To that end, participants were given a program itinerary containing four tracks or Ports of Call and included various interventions: (1) Education and Culture (tutoring, academic enrichment via African Centered Olympics, college preparation activities, and rites of passage (summer cohort)); (2) Entrepreneurialism (developing a business plan, beginning their own business, budgeting and basic business accounting, introduction to entrepreneurial mentors), (3) individual and family support (individual counseling, social skill enhancement, anger management, family counseling), and (4) structured recreation (physical development and teamwork skills).

All registered youth were automatically enrolled into the Individual and Family Support Track (Destination Port #3). Each youth and their caregiver selected at least one additional track (Port of Call) to complete their Passport itinerary. Tracks (Ports) 1, 2, and 4 were offered one day per week. The Individual and Family Support Track (Port of Call #3) was provided two days a week; this guaranteed that all enrolled youth/families received these interventions. Additionally, targeted cultural activities occurred during non traditional hours and/or on the weekends. Such outings were successful auxiliary educational components for the youth and their families. Events served to build protective factors, enhance participants' future orientation, and expand youth's world view beyond the bounds of at-risk behaviors. Educational/cultural events included the Lion King Opera, a Wayne State College Tour, The Great Debaters movie outing, the Wayne County Community College Girls Empowerment Conference, a Detroit Tigers Game, bowling, attendance at an HIV prevention/sexual awareness play, the Detroit Zoo, and structured recreation at Belle Isle.

Participants

Youth enrolled in BFDI's Youth Assistance "Passport" Program were required to have a referral and complaint filed by their parent with the Wayne County Court System or with the police department. Thereby, the following youth were eligible for services: (1) Youth between the ages of 7 and 17 who were at risk of entry into the juvenile justice system as defined in the Wayne County Ordinance 96-86 [Revised] 2/16/96, (2) Correct Course Youth who were less than 17 years of age, referred by the Wayne County Prosecutor's Office and Juvenile Assessment Center (JAC), and (3) Diversion youth, with status and misdemeanor offenses, who were less than 17 years of age and had been assigned to the Court's Informal Docket. The total number of youth served was 88.

Results

Eighty Child Care Fund (CCF) eligible youth and eight At-Risk youth were enrolled and disenrolled from the program during the 2007-2008 fiscal year. Eighty-three youth were discharged successfully; 75 CCF youth and 8 At-Risk youth. In all, 94% of youth completed the Program successfully. There were three unsuccessful discharges due to re-offenses

at the close of the cohort; two youth were discharged unsuccessful due to testing positive for substances at the exit interview. All five unsuccessful discharges were CCF youth. For those youth who have been out of the program for one year, all have remained successfully with the exception of one who has been identified as unsuccessful due to re-offending; this youth was an At-Risk youth. Overall, 96.4% youth expressed satisfaction with the services provided.

Conclusion

The Passport Program developed by BFDI is an effective intervention program. The initial success of the program will help work to ensure that these youth have the skills and access to resources to meet the program's goals. Namely, they will attend school, abide by the law, and grow up to be productive citizens.

Beacon of Light: A Parent's Perspective on the Impact of Diversion

Presenting: Dorindia Sheppard & Shyanne Depriest

Parents of children involved in the juvenile justice system can often be ignored, confused, and left feeling that no one is listening to them. The Correct Course program, with the JIFF interview that has a parent version, allows caregivers to share their insight into their child's strengths and needs across life domains. It provides parents with a voice and vehicle to have that voice heard by those making decisions about their children's lives, such as officers of the court and service providers. Parents report that for the first time their voices are being heard and taken seriously. In addition, by going over the JIFF results with the JAC/Correct Course workers, parents are learning about their child as well as learning to trust that this program is focused on their child's best interests. In this talk Dorindia Sheppard who has gone through the system will speak about her experience, how it was different from previous experiences, and provide some suggestions for further improvement. In addition, ways that the programs could further engage parents in the process will be discussed.

Session 14 » 1:30–3:00 pm » Salon J

Symposium

Beyond Didactics: Emerging Evidence on EBP Implementation Strategies in New York State

Chair: Kimberly Hoagwood

As efforts to disseminate Evidence-Based Practices (EBPs) to community settings within states progress, a number of questions are beginning to surface regarding the most effective strategies for dissemination, implementation, and training. Attempts to bring EBPs into real-world practice have been met with varying degrees of success. Studies are highlighting some of the barriers; they include organizational, structural, fiscal, and practical. This symposium will present findings from four studies in New York that are examining different approaches to improve the uptake and use of psychosocial therapies by practicing clinicians and supervisors within clinics, community programs, and schools that are part of a major state-wide Evidence-based Treatment Dissemination Initiative.

In New York, a NIMH-funded Developing Center for Implementing Evidence-Based Practices for Children (Hoagwood, PI) is examining strategies targeted at organizational change, clinician behavior, and consumer involvement to improve the acceptance, uptake, use and sustainability of EBPs. One of the Center's core projects is the Evidence-Based Training Dissemination Center (EBTDC) Project, a partnership between Columbia University and the New York State Office of Mental Health to train 400 clinicians per year in EBPs for youth. Four studies, built from the EBTDC, are examining different strategies to improve the dissemination of cognitive-behavioral therapies in clinics, schools, and other community settings. The approaches include specific behavioral change strategies used during consultation after training to enhance clinicians' use of skills; supervisory engagement strategies; and engagement and empowerment of families through family to family support. A state-wide, flexible, and "distance-learning" training & consultation model will be described. Strategies targeting motivation and engagement of families and youth through inclusion of family advocates will be described. The overall goal of this symposium is to present emerging evidence on strategies states are using that target different levels of the implementation process in order to improve dissemination of EBPs for children and families.

Initial Findings and Implications of the Evidence-Based Training Dissemination Center (EBTDC)

Presenting: Alissa Gleacher

Overview

The Evidence-Based Training and Dissemination Center is an initiative through the New York State Office of Mental Health (OMH) and a partnership with Columbia University to train clinicians in OMH-licensed clinics in the use of evidence-based treatments (EBTs) for youth. One of the primary goals of the EBTDC is to evaluate the dissemination of this training initiative and consequently improve the quality of routine care in outpatient clinics beginning with youth with trauma symptoms or depression. Because brief trainings are rarely effective in changing clinicians' behaviors, the EBTDC utilizes a double-pronged approach with an intensive 3-day training followed by a year of bi-weekly telephone consultations in the actual application of the treatments. The EBTDC has been training up to 400 individuals per year over the past two years in evidence-based treatments for youth with trauma and depression. In the first two years of the project, eighteen initial three-day workshops were held, resulting in the training of 769 clinicians and supervisors. The workshops provided education and training in the use of the following manualized treatments: CBT for Child and Adolescent Depression (Curry & Stark, 2006) and Trauma Focused CBT (Cohen, Manarino, & Deblinger, 2006). All training for year-one participants was completed by Fall 2007. Bi-weekly phone consultation for individuals participating in the second year of the project is still ongoing.

Results and Implications

Analyses of data from year 1 illuminated several interesting trends. One, the data suggest that large-scale dissemination is feasible as the majority of clinicians completed the program. Overall, 72.3% of the total sample completed the entire consultation year. Given the demands of participation in terms of time and clinician resources, this is a high

rate of clinician retention and a low rate of attrition. The primary reason for dropping out of the program (stated by 20.7% of drop outs) was leaving or changing job. In terms of completing the program, 191 individuals (79.5%) of clinicians who did not terminate prematurely met the completion criteria for the program. Second, the results highlight interesting differences between consultants such that ANOVA revealed significant differences between consultants with respect to attendance, drop-out, and completion rates. These findings are especially relevant to design of future training endeavors.

Disseminating Evidence-Based Treatments for Children: A Microanalysis of Consultation Calls as an Ongoing Training Strategy

Presenting: Sandra Pimentel

Overview

In the effort to disseminate evidence-based psychotherapy interventions for children, an emerging model involves conducting a training workshop in the target intervention for community clinicians followed by consultation conference calls. Calls are hypothesized to provide a real-time learning forum during which clinicians can discuss aspects of treatment implementation via case review with expert consultants. Although the treatments themselves are manualized, and workshops generally include didactic and interactive educational methods for training in these manuals, little evidence supports the use of workshops in the absence of additional educational and consultative strategies for the transfer of evidence-based knowledge and skills. Reviews of related evidence from efforts to change physician practice behavior via formal continuing medical education (CME) workshops consistently have found that workshop-based training has little direct influence on changing practice or process of care unless they were coupled with additional supportive strategies (e.g., Davis 1998; Davis, Thomson, Oxman, & Haynes, 1995).

Methods

This presentation will include data from a microanalysis of consultation calls ($n = 40$) as they are being utilized in the Evidence-Based Treatment Dissemination Center (EBTDC). The EBTDC is a program within the New York State Office of Mental Health's statewide initiative to disseminate evidence-based treatments. EBTDC provides training and consultation in Trauma-Focused Cognitive Behavioral Treatment (TF-CBT) for child trauma and CBT for childhood depression. To date, upwards of 800 clinicians (400 in year 1; 400 at present) attend a three-day workshop on these treatments and are participating in one year of bi-weekly telephone calls with an expert CBT consultant. Forty of these calls were randomly selected from the ongoing EBTDC project and their content is being coded by experienced and reliable ($> 75\%$) CBT coders. Coders are rating minute-to-minute verbalizations on these consultation calls as they are made by participating clinicians and consultants and code on-task versus off-task verbalizations, the presence of various content domains (e.g., use of CBT-specific techniques, discussion of CBT principles, assessment, patient motivation) and consultants' use of educational strategies (e.g., role play, didactics). Data collection is underway. Analyses will examine whether specific task-related behaviors are associated with indicators of changing clinician practice behavior. Results will be discussed in relation to the need to develop cost effective methods for evaluating the impact and effectiveness of large-scale, publicly funded dissemination programs.

A Family Support Service Model for Implementing Evidence-Based CBT in Real-World Settings

Presenting: James Rodriguez

Contributing: Geraldine Burton

Introduction

Prior research suggests that the effectiveness of evidence-based treatments attenuates in real-world practice settings. In part, this decrease in effectiveness is attributed to the general challenges faced in delivering treatment services in practice settings that includes a host of family-level psychosocial stressors that complicate and impede the assessment, engagement and retention of children in treatment. A number of parental perceptual and concrete barriers have been identified as contributing to poor rates of service use among parents. These barriers are particularly salient in low-income urban settings with high rates of poverty. Consequently, strategies designed to improve outreach and retention of families in children's mental health services may increase the impact of effective treatments in routine practice settings. E3: Engagement, Empowerment, and Evidence-based Treatment is a study that uses an experimental design to test a family support service delivery model to examine family processes associated with the implementation of evidence-based treatments for childhood trauma and depression related disorders.

Project Framework

The goal of the E3 project is to increase initial engagement, retention, satisfaction with treatment, therapist fidelity to treatment protocols, and child outcomes among families seeking treatment for childhood depression or trauma. The E3 model entails pairing clinicians trained in evidence-based cognitive behavioral therapy for trauma and depression with parent advocates trained in strategies to empower parents through an array of family support services. Clinician-Advocate teams are trained in evidence-based strategies to increase engagement, investment and retention in treatment. Sites with clinicians trained in evidence-based treatments (EBT) for childhood trauma and depression at 8 clinics in NYC have been randomly assigned to either to the E3 condition or to EBT training/consultation only. Parent-child pairs seeking treatment services at participating clinics are assessed for trauma or depression using a common evaluation battery. Consultation with project staff is used to ensure the proper identification of cases and to provide ongoing support to promote treatment fidelity. During the course of treatment children's treatment attendance and weekly ratings of distress, and clinician adherence to manualized CBT are tracked. In addition, bimonthly interviews are conducted with parents to assess a number of parental factors critical to treatment investment, including barriers to participation, expectations for treatment, caregiver stress, and satisfaction with treatment. Preliminary data on the project outcomes are now available, and findings offer implications with respect to the implementation of evidence-based cognitive behavioral therapy for children.

Transporting Evidence-Based Practice to School Settings: Examining Strategies for Consultation

Presenting: Jessica Mass Levitt

Introduction

Approximately, 70-80% of American children with mental health service needs receive care in a school setting, making schools the primary providers of mental health services to children and adolescents above any other type of mental health service setting (Farmer et al., 2003). However, the types of mental health services typically provided in schools vary with very few schools providing evidence based treatment approaches (Henggeler et al., 2003; Rones & Hoagwood, 1998). Attempts to disseminate evidence based treatments to community practice settings such as schools often face a variety of barriers including low rates of new practice adoption by clinicians after training or poor clinician fidelity to the treatment model. The EBTDC model combats this obstacle by provide ongoing consultation phone calls to clinicians for 1 year after the initial training.

Methods and Procedures

The current study uses a randomized design to investigate two strategies for providing this consultation: consultation as usual vs. consultation utilizing specific clinician behavior change methods known as “mental contrasting” and forming “implementation intentions” (MC/II). Briefly, MC/II encourages clinicians to first identify key motivations and personal reasons why they would and should want to adopt a specific evidence based practice procedure. Then, clinicians are asked to identify any and all obstacles that they perceive will actually interfere with their adoption of the evidence based practice (this technique is known as “mental contrasting”). Finally, clinicians are helped to develop tailored strategies for how they will overcome their own perceived obstacles (termed “implementation intentions”).

Results

It is expected that clinicians who are randomly assigned to the MC/II consultation model will more quickly identify appropriate children for the evidence based treatment and will more closely adhere to the evidence based treatment during actual treatment sessions. In addition, the study explores child and parent reports of changes in child symptoms, satisfaction with the treatment, CBT learning (i.e., a proxy measure for clinician adherence to treatment model), and alliance with therapist. Study results should suggest direction for overcoming barriers to effective dissemination of evidence based practices in general and in school settings specifically.

Monday, March 2 » 3:15 pm

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	<i>Elizabeth M.Z. Farmer & Maureen Murray</i>	
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Special Session B » 3:15 - 4:45 pm » Meeting Room 8-10

A New Report from the National Research Council and Institute of Medicine: Preventing Mental, Emotional and Behavioral Disorders Among Young People: Progress and Possibilities

Panel: C. Hendricks Brown, Peter Pecora & Mary Ellen O'Connell

On February 13, 2009, the National Research Council and Institute of Medicine released a new report, *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. The report summarizes the progress made in prevention research over the last 15 years and prioritizes the research agenda for the future. It examines definitions of prevention, the developmental, epidemiologic, and ecological bases for developing and testing preventive interventions

and reviews the progress made from rigorous experiments across the life span and contexts. It also outlines advances in genetics and neuroscience, and implementation science, that offer new opportunities for conducting prevention research and moving these prevention programs that benefit our children much more broadly into community, social service, and institutional settings. The panel will present this newly released report, with a focus on recommendations relevant to research and policy.

Session 15 » 3:15–4:45 pm » Salon A-B

Symposium

Parent Support: Emerging Empirical Evidence – Part 2

Chair: Krista Kutash

Discussants: Marlene Penn & Barbara J. Burns

This second part of this symposium series will examine several models of parent support programs and emerging empirical evidence of their effectiveness. In the first presentation a theory-based training model for parent advisors who provide peer-to-peer support in New York will be described. Pilot data from four studies on the impact of this empowerment training program on parent advisors and parents will be presented.

The second presentation will provide an overview of NAMI Basics. NAMI Basics is a six-session peer-led educational program for parents and caregivers of children and adolescents with a mental illness. Prior studies have identified these course elements as instrumental: (1) recognition of mental illness as a continuing traumatic event; (2) sensitivity to subjective emotional issues; (3) need for help with the day-to-day burdens of care and management; (4) development of confidence and stamina; and (5) empowerment as an effective advocate. A two-state evaluation is currently underway to examine the impact of NAMI Basics on parental stress, parental empowerment, parental self-care, and family problem solving and communication skills.

These presentations will be followed by a discussion from a parent's perspective. The Symposium will close with an overall discussion by Dr. Barbara J. Burns, a nationally recognized mental health services researcher.

Parents as Change Agents: The Parent Empowerment Program for Parent Advisors

Presenting: Kimberly Hoagwood & Geraldine Burton

Contributing: James Rodriguez, Marlene Penn, Serene Olin, Priscilla Shorter & Nancy Craig

The family social context is a critical factor in the implementation and outcomes of services and treatments for children (Burns et al., 1995; Farmer, Burns, Angold & Costello, 1997). Nationally, a growing number of studies are examining targeted support services for parents or caregivers of children with mental health needs. A comprehensive review of structured family support interventions has been undertaken in collaboration with executive leadership from NAMI, Federation of Families, and CHADD. Its aim is to promote attention to this emerging area, to encourage conceptual consistency, and to strengthen the scientific agenda. Highlights from the review will be summarized in the presentation.

Strategies to improve engagement and retention of families in services have included creation of professional roles for family members, sometimes called family associates, family support specialists, or family advisors (Hoagwood, 2005; Koroloff & Friesen, 1997). As part of a long term plan to strengthen family support services, New York State, the Office of Mental Health (NYSOMH) is expanding the number of professional family advisors (FAs) throughout its 62 counties and in NYC (Roussos, Berger & Harrison, 2008). FAs work with some of the most distressed parents and caregivers in the mental health system. In the Western Region, a group of family advisors, led by Nancy Craig, have developed a structured strengths-based assessment system (called Family CANS) to support their professional work.

To provide training and consultation to strengthen the competencies of FAs and their knowledge about evidence-based practices, a collaborative team comprised of advisors, policy-makers, and researchers collaborated over 6 years to develop and pilot test a program, called the Parent Empowerment Program (PEP).

The PEP model consists of two phases. The first phase consists of 40-hour in person training provided by an experienced family advisor and a mental health professional, generally a psychologist, psychiatrist, or social worker. Training is generally in small groups of 5-12 persons. Phase Two consists of bi-weekly 1 hour telephone consultation sessions provided monthly for 6 months by the same team.

Theoretically grounded in the Theory of Reasoned Action and Theory of Planned Behavior (Ajzen, 2001; Ajzen & Fishbein, 1981), the training targets knowledge about effective evidence-based treatments, collaborative skills, self-efficacy, and specific strategies to increase family support, education and empowerment, with the goal of improving family participation and access to necessary services. Sessions include didactic training, practice exercises, and group discussion. The PEP manual contains eight modules covering: (a) application of theories of change to parent empowerment, (b) communication skills, (c) engagement and boundary setting skills; (d) priority setting and problem solving skills, (e) the mental health system of care and navigating the system (f) service options through the education system (g) understanding psychiatric disorders, the diagnostic process and treatments, and (h) group management. The PEP also incorporates components of McKay's engagement strategies, which were developed over the past decade to improve retention of urban, low-income families in community services and alliances among clinicians and families (McKay & Bannon, 2004).

The overall goal of the PEP is to improve family advisors' knowledge about EBP's in children's mental health, professional skills, self-efficacy, and collaborative skills in working directly with parents. A recently completed NIMH-funded pilot study of PEP used a randomized design to assess the program's impact on family advisors' and caregivers' knowledge, skills, self-efficacy and working alliance. This presentation will describe findings from this study.

The study used an experimental design in which 32 ethnically diverse advisors were randomly assigned to receive either PEP ($n = 18$) or training as usual (TAU, $n = 14$). A random sample of 124 low-income minority parents receiving services from PEP or TAU advisors were assessed to examine their self-efficacy and working alliance with advisors. Results will be described. Implications for improving research on family support and on the role of family advisors will be described.

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Development, Implementation and Evaluation of the NAMI Basics Education Program

Presenting: Teri Brister

Introduction

Research has shown that more than one half of all individuals who experience mental illness in their lifetime reported an onset of symptoms prior to age fourteen. Recent studies have also estimated that from twelve to twenty-two percent (7.5 to 14 million) of America's youth currently suffer from a psychiatric disorder. According to the National Institute of Mental Health (NIMH), regardless of specific diagnosis or age group, no other illnesses damage so many youth so seriously. The consequences of not recognizing the symptoms and providing treatment range from minor

difficulties with the school system to encounters with the juvenile justice system to the infliction of physical harm to the individual or others, including suicide.

These statistics present several major challenges for parents and caregivers of children and adolescents in today's society. The first challenge is recognizing the signs and symptoms of the illness in order to diagnose it as early as possible. A second challenge is choosing the appropriate response and treatment once the symptoms are identified. The third and perhaps greatest challenge is learning how to live with the illness that has taken over the life of the child/adolescent. One important step in overcoming these challenges is for parents and other caregivers to become knowledgeable about the illnesses themselves. This education process requires family members to learn how to work collaboratively with mental health and school professionals.

Support and education for these families is a top priority of the National Alliance on Mental Illness (NAMI). While an assortment of programming for young families existed in several regions, there was no comprehensive, national program that effectively met the needs of diverse families across the country. This presentation will provide an overview of the development, implementation and evaluation of the newest NAMI Signature Education Program, NAMI Basics. Developed in 2007, NAMI Basics is a six-session peer-led educational program for parents and other caregivers of children and adolescents with mental illness.

Program Elements

Program Development began with a review of existing family, peer-led educational programs to compare program content and teaching approaches as well as to identify gaps in content. An advisory committee was formed of NAMI family program experts from around the country to help ensure the development of a program that would meet the diverse needs of families.

The result was development of a program based on the success of NAMI's existing signature education programs for consumers and families, drawing on course elements which have been tested and found to be effective in the field. These elements include:

- recognition of mental illness as a continuing traumatic event for the child and the family;
- sensitivity to the subjective emotional issues faced by family caregivers and well children in the family;
- recognition of the need to help ameliorate the day-to-day objective burdens of care and management;
- gaining confidence and stamina for what can be a life-long role of family understanding and support; and
- empowerment of family caregivers as effective advocates for their children.

The process of emotional learning and practical insight for families occurs most readily, and dependably, on the guided group process which occurs when individual family members are together.

Implementation

The NAMI Basics Education Program is made available through state NAMI organizations. Parents and other caregivers are recruited to apply to participate in a rigorously structured weekend teacher training in their states to become certified to teach the program. The course is taught using a co-leader model.

Since November 2007, eighteen states have hosted teacher trainings and those teachers have gone on to provide classes in their home communities. There are thirteen additional NAMI state organizations

who will initiate the program in 2009. An update will be provided during the presentation indicating all current states in the program, including the number of teachers and classes that have been offered.

Evaluation

The presentation will discuss the results of the evaluation of the first eighteen pilot classes which were held in Illinois, South Carolina and Utah between January and May of 2008. The pilot study was conducted by Dr. Paul Deal of Missouri State University.

There will also be an overview of the current research now underway in classes being taught in Mississippi and Tennessee between October 2008 and May 2009.

Both of these research projects focus on the impact of the program in the dimensions of knowledge level, empowerment, and self-care skills of participants.

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¹ The complete NAMI Basics Education Program reference list is available upon request.

Session 16 » 3:15 - 4:45 pm » Salon C

Symposium

The Perfect Storm – The Convergence of Data, Process and Dialogue for System of Care Development

Chair: Jody Levison-Johnson

Discussant: Mario Hernandez

Systems of Care are about effecting meaningful change which ultimately improves the lives of children and families across the country. Real change efforts must be grounded in a foundation that establishes the who, what, why and how for the initiative and must be adaptive and responsive to new information that is learned on the ground. Harnessing the power of the myriad data sources available and ensuring they are part of a well defined process and resulting dialogue creates the perfect storm for system of care development. This symposium will share the experience of two funded system of care communities, Monroe County, NY and the State of Oklahoma in ensuring that data, in all forms, is integrated into a well-established process that promotes discussion and discourse and ultimately continuous quality improvement (CQI) for developing systems of care. Additionally, specific examples from the CQI Progress Report will be introduced as opportunities to promote the use of these processes for dialogue and discovery for data captured as part of the National Evaluation of systems of care. The continued need for development of clear measures of transformation and system development will be highlighted as next steps for the evolving system of care movement.

Waves of Change: Targeting and Measuring Systems Reform in Oklahoma

Presenting: Keith Pirtle

Introduction

Oklahoma has used the Systems of Care model to create the perfect storm for statewide systems change and wraparound expansion. This paper will share Oklahoma's process for using data and dialogue to target and measure systems transformation. The identified outcomes, strategies and activities for defining and implementing systems reform, and state developed tools to measure both process and outcomes will be shared as examples of how to effectively quantify a community's waves of change.

Oklahoma's Systems of Care journey began in 1999 with a state level conversation around unintended negative outcomes for families in need of care. Families in desperate need of mental health and other support services asked the State Legislature to make it easier to give up the custody of their children to the state so they could receive the services they needed. The state believed there were better ways to support families in need and as a result, child serving state agencies and families came together to find an alternative method for families to obtain needed services and supports and minimize family disruption whenever possible. The clear answer was the Systems of Care philosophy and the wraparound approach to serving families. The group of state level stakeholders quickly adopted two main goals: transform the behavioral health system using the Systems of Care values and principles and provide wraparound services statewide to families with the most complex needs.

The first step was clear. Define what transformation of the statewide behavioral health system would look like based on the systems of care values and principles. This equated to the establishment of locally controlled community based systems of care that meet certain standards.

The next step was to define the desired outcomes for families that were enrolled in a wraparound process. These included a reduction in out of home placements, school detentions and arrest. Though other measures continue to be used, these have continued to be the state's highest priorities for its system of care initiative.

Methodology

Creating and measuring statewide behavioral health transformation is not an easy task. The state was aware that one of the ways to facilitate this change was through the creation of local systems of care throughout Oklahoma. A framework for local communities to follow was developed that included the creation of a local community team. The local community team was responsible for oversight of the implementation of wraparound services and providing support and service coordination for families. The local team was also charged with engaging in local barrier

busting and ensuring that families and youth were involved in leadership roles both within and outside of the project. Though each community is different, key indicators of success emerged over time, including: whether the chair of the community team understands his/her role and facilitates the community team meeting and; whether family members are active participants in the community team. Questions like these were compiled into the *Oklahoma Systems of Care Site Assessment Checklist* (Pirtle, 2002). The checklist helped new communities understand the tasks they needed to complete to be successful. In addition, the checklist ensures that more established systems of care better understand their strengths and areas for growth and development.

Measuring the desired outcomes for families that receive wraparound services was far more straightforward. Using a questionnaire, families were asked at the initiation of services if their child had been placed outside of the home in the last 90 days. This question is again asked at six months after wraparound services had begun. Questions are also asked at the baseline and six month follow up that establish whether the identified child had been in school detention or arrested within the last 90 days.

Findings

Through this process, Oklahoma Systems of Care has been able to maintain quality control of the many local systems of care projects and identify specific technical assistance needs of communities. The project has expanded from five counties to 41 which has been possible largely as a result of defining what an effective local system of care looks like and by measuring its progress over time at the local level. Annual site reviews using the site assessment checklist have demonstrated improvements over time at the local level.

Oklahoma has also seen a 45% decrease in out of home placements. Tracking out of home placements over time has also given the state the ability to focus technical assistance to several aspect of the wraparound process. This includes working closely with inpatient providers to provide for a better transition in and out of hospitalization as well as targeting additional assistance to Systems of Care communities whose out of home placement rates do not meet the state benchmark. The state has also seen a 45% decrease in school detentions and a 49% reduction in arrests.

Conclusion

Systems transformation is a lofty goal. It requires defining what success looks like through identifying the community's outcomes, developing good processes and then methods to measure them. Continuous quality improvement takes constant assessment of where you are and where you want to be. Oklahoma's journey has been one of identifying success, developing solid processes and strategies, and then developing tools, to measure them. It is a never ending cycle that creates incremental waves of improvement which ultimately will result in systems transformation.

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Waves of Change: Examining System-Wide Indicators of Performance in Monroe County

Presenting: Jody Levison-Johnson & Kathleen C. Plum

Introduction

The ACCESS logic model identifies several outcomes including: enhancing community-based services to ensure access through non-acute settings and increasing public mental health service utilization by youth of color. To assess progress, public mental health service utilization data are regularly reviewed with attention to point of first contact for all new entrants and use by youth of color. This paper will provide an overview of data to date and highlight resulting continuous quality improvement efforts.

Guided by the systems of care approach (Stroul & Friedman, 1986), the Monroe County, New York, Achieving Culturally Competent Effective Services and Supports (ACCESS) initiative is working to transform the service delivery system for children and youth to one that is family driven, youth guided, culturally and linguistically competent, best practice oriented and trauma informed. Several comprehensive project goals were initially identified and then further developed through an interactive logic model process (Hernandez & Hodges, 2003) with stakeholders and community partners. Specific areas of focus included the intent to reduce the high use of acute settings to enter the mental health system and the need to increase public mental health service utilization for youth of color due to their disproportionate representation in the juvenile justice and child welfare systems. Therefore, two major indicators for the system of care are to increase the rates by which youth enter the system through non-acute community-based settings and increase the rate of mental health service utilization for youth of color. To assess progress on these two indicators, Monroe County has used their county-wide data collection and analysis system, the Behavioral Health Community Database (BHCD). This paper will provide an overview of BHCD data for the year prior to ACCESS commencement (2005) and the first two years of this six-year project (2006 and 2007) and highlight resulting continuous quality improvement and follow-up efforts.

Methodology

Data from the Monroe County Behavioral Health Community Database (BHCD), a collection of demographic and utilization variables from all publicly funded mental health provider agencies, were used to analyze performance on these two indicators. With the exception of private providers, all public mental health agencies in Monroe County are required to collect and submit data to the BHCD using a standardized reporting format. Thus, data were available for all youth in Monroe County that accessed public mental health services unless they received services from a private provider. Comparisons were also made to the entire population of youth in Monroe County which was approximately 220,000 in 2006 (U.S. Census Bureau, n.d.). Data indicators included point of first contact for all children and youth and overall service utilization. Data were analyzed by program category, race/ethnicity, and other demographic variables. For the point of first contact indicator, youth were included in the count for the program where they initially entered the system even if they re-entered the system multiple times. For overall service utilization, youth were counted in every program in which they received services.

Findings

Overall, new child and youth entrants to the public mental health system have decreased by 9% from 2005 to 2007 while the youth population of Monroe County youth has remained stable. This decline is true for all racial/ethnic groups with the exception of Hispanic/Latino

youth and Asian/Other for which there was an increase of almost 8% and 18% respectively. Youth entered the system most frequently through outpatient services. While the proportion of new entrants through outpatient increased slightly between 2005 and 2006 (from 65% to 69% respectively), the proportion fell slightly in 2007 to 67%. This overall decline is true for all racial/ethnic populations with the exception of Hispanic/Latino and Asian/Other youth who increased entry into the system through outpatient services. Entry into the system through acute services shows a similar trend, with significant proportional declines from 2005 to 2006 (32% to 23% respectively) and then a slight increase in 2007 to 25%. The proportion of new entrants through community-based services (including case management, in-home crisis, vocational services, family support, etc.) has continued to increase from 2.9% in 2005, to 8.1% in 2006 to 8.5% in 2007.

Over this same three year span, the total number of unduplicated youth in Monroe County utilizing mental health services has decreased from 8,484 in 2005 to 8,030 in 2007. Despite this, the total number of youth of color receiving services has increased while the number of Caucasian/White youth has declined by approximately 8%. When comparing 2005 to 2007, service utilization increased for youth of color in all service areas (outpatient, community support, emergency/acute, inpatient) with the exception of residential care which showed a slight decline. While the use of less restrictive settings (outpatient, community-based services) increased significantly between 2005 and 2007, the use of inpatient hospitalization and emergency room visits also increased during this time span.

Conclusion

The ability to establish and measure overall system-wide indicators of performance is a critical component of system of care development for all communities. Using a logic model process to initially determine a community's overarching goals and intentions and delineate intended impact of system of care efforts allows communities to measure progress in a variety of ways. In Monroe County, the Behavioral Health Community Database has proven a valuable resource to better understand the impact of the County's efforts to increase entry and engagement in services by youth of color.

While fewer youth overall are entering the public mental health system since the inception of ACCESS, the overall proportion of all youth entering through outpatient and community-based services has increased from 2005 to 2007. In addition, the total number of youth of color utilizing all types of services has increased.

These findings suggest several potential next steps for system of care partners including continued discussion regarding successful outreach/engagement strategies for youth of color and development of a better understanding of the reasons for the decrease in the population of White/Caucasian youth served. A more in-depth analysis is necessary to determine for example, which programs youth accessed following their entry into the system and the rate at which their involvement was sustained.

The BHCD provides a wealth of opportunity for mental health administrators and researchers. However, the process of collecting and compiling data needs to be followed closely with honest dialogue with all relevant stakeholders to establish a collective understanding of what these data mean for Monroe County and ensure the convergence of elements to create the perfect storm.

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Waves of Change: Using the CMHI Benchmarking Initiative and Progress Report as a Model for System Improvement

Presenting: Katrina Bledsoe

Introduction

The Children's Mental Health Initiative's *CMHI Benchmarking Initiative and Progress Report* is designed to encourage dialog between system of care communities and technical assistance partners concerning mental health services for children and their families. The presentation will discuss the CQI communication feedback loop and the *CQI Progress Report* system level indicators, and how they can provide information on to communities for system-wide change.

What is Continuous Quality Improvement (CQI)?

Continuous Quality Improvement (CQI) is an approach that helps to ensure quality assurance by emphasizing and identifying the process of functioning of the *organization* and its *system*, rather than focusing on the individuals who work within, or receive services from the system. Such a process requires that staff identify, plan, and implement ongoing improvements in services and service delivery. Since CQI seeks to improve the system, rather than the individual, there is a need for objective data to analyze and improve processes, rather than anecdotal evidence. In using objective data, CQI provides an effective way to assess and monitor the delivery of services to make sure that they are consistent with an organization's best practice principles.

The Comprehensive Mental Health Services for Children and Their Families Program (CMHI) CQI Benchmarking Initiative

In keeping with the goals of CQI and applying them to mental health services that affect children and their families, the *Comprehensive Mental Health Services for Children and Their Families Program (CMHI)* has initiated the *CQI Benchmarking Initiative* which helps grant communities adhere to System of Care (SOC) principles in providing mental health services that are (a) family-driven; (b) individualized; (c) culturally and linguistically competent; (d) least restrictive in service planning; (e) community-based; (f) accessible; (g) interagency collaborative; and (h) coordinated and collaborative. To this end, the Initiative makes extensive use of the *CQI Progress Report* which provides data on key performance indicators encompassing the SOC key principles. This tool is designed to use performance measurement and benchmarking to support the quality, continued improvement, and sustainability of grant communities, during and post grant funding. Thus, the *CQI Progress Report* is designed to instigate conversations within communities about their systems of care, and help to provide data driven information that can assist program development and dissemination.

The CQI Communication Feedback Loop and the CQI Progress Report

A major goal in the development and maintenance of a system of care community is developing CQI processes that inform system of care development and transformation efforts. Thus, the Initiative is designed to serve as part of a continuous feedback mechanism loop for grant communities. Monitoring and comparing the progress of grant

communities in implementing systems of care provides an opportunity to see what is working across sites and allows benchmarking across similar systems of care. Providing data on key performance indicators demonstrates concrete data on performance indicators that are reflective of the systems of care goals and objectives, and encourages system reform where necessary. The communication feedback loop which is based upon coordination and communication between program partners and SOC staff, encourages basing system services and provision on the organization's theory of change they hope to produce; identifying information sources; gaining access to those information sources; designing actions and modifications to their system of care; and engaging in reassessment to continually improve the services that address the mental health needs of children and their families.

The *CQI Progress Report* is a tool designed to facilitate this communication feedback loop, by tracking progress toward meeting program goals and objectives, and to help communities to make informed decision about what's working, what's not, and what are reasonable expectations for the system and system reform. Community-level staff work with federal program partners to engage in a communication feedback loop designed to discuss performance as reported on the *CQI Progress Report*, identify strategies to improve performance, and develop a plan to implement those strategies to improve services and service provision. Participation at the community level is critical to the

communication feedback loop. Staff and representatives at the local level provide context for their performance and to identify strengths and challenges that contribute to their performance.

The *Progress Report* focuses on 35 indicators nested within five domains: (1) System level outcomes; (2) Child and family outcomes (which has two sub-domains); (3) Satisfaction of services; (4) Family and youth involvement; and (5) Cultural and linguistic competency. Thirteen system level indicators that focus on service accessibility, service quality, and service appropriateness help to measure the extent to which the service system is meeting the SOC goals and objectives by providing services that are family-focused, accessible, appropriate, coordinated, and involving multiple agencies. These indicators are helpful in illustrating system change and reform.

Long-term Sustainability for Systems of Care

The *CMHI Continuous Quality Improvement Benchmarking Initiative* is designed to provide information that allows development of services representative of the system of care principles development, ensure long-term sustainability, encourage reform of mental health services across community, and provide guidance in improved program planning. Such planning and subsequent reform can help ensure that the mental health needs of children and their families are met in a humane and family driven manner.

Session 17 » 3:15 - 3:45 pm » Salon D

Knowledge of and Attitudes Toward Services among Youth Transitioning from Foster Care

Presenting: Michelle Munson, Sarah Narendorf & Curtis McMillen

Introduction

Older youth in foster care are heavy mental health service users while in care (McMillen et al., 2004). A recent study, however, found that service use rates dropped by 60% from the month preceding care to the month after leaving care among 325 transitioning foster care youth (McMillen & Raghavan, in press). Research has shown that attitudes and knowledge are related to mental health service use (i.e., Abram, Paskar, Washburn, & Teplin, 2008). Yet, we know little about these factors among older youth in foster care, a sub-group whose independent views are increasingly important as they leave care. The present study aimed to understand the knowledge older youth possess when presented three scenarios involving need for services and whether knowledge of and attitudes towards behavioral health services varied by demographic and clinical factors, such as gender, maltreatment, diagnostic history, and past service use.

Methodology

The present study utilized survey research methods, face-to-face interviews and a vignette methodology. Two hundred forty four older youth transitioning from foster care in the Midwest, all of whom met criteria for at least one DSM-IV psychiatric disorder were asked what they would do if faced by three distinct scenarios involving depression, violence, and substance abuse, respectively. Responses were coded by the research team. For description, we trichotomized codes into three categories, "little," "some," and "specific" knowledge. A summary scale that combined scores from the vignettes was utilized to capture an overall level of knowledge. Attitude was measured utilizing the confidence in practitioner subscale of the Attitudes Towards Seeking Professional Psychological Services Scale (Fisher & Turner, 1970). Gender, race, substance use, and where youth were living were reported by youth. Standard measures were utilized

to determine past service use, maltreatment, and psychiatric diagnoses. Frequencies and measures of central tendency were examined, bivariate relationships were examined, and ultimately multivariate models were constructed to best explain the variability in knowledge and attitudes.

Findings

Sixty-six (27%) and seventy-nine (32%) of the youth reported little knowledge of what to do when presented with the violence and depression scenarios, respectively, whereas only 18 (7%) reported little knowledge when presented the substance use scenario. 73 (30%) youth were able to recognize help was needed and specify where to go when presented the substance use scenario, as compared to 25 (10%) and 32 (13%) for the violence and depression scenarios, respectively.

Youth responses regarding what to do if a friend is "smoking crack cocaine all of the time" and it's "ruining his life" were specific, "...lock him in my apartment until he could get into Ozark Center..." With regard to depression, 133 (55%) reported an adult should be enlisted, "talk to someone—find counselor to talk to..." indicating some knowledge, however, what to do is not specified. With regard to violence, 30% reported there was no need for help, they didn't know what to do, or, "I'd stay out of it." Very few youth, 9%, could recognize a need and suggest a specific strategy, such as "...tell him to check in to a hospital, St. Johns..."

Bivariately, gender, race, maltreatment history, history of depression and PTSD, county of residence, past year outpatient therapy, previous substance use, and attitudes towards services were all related to knowledge ($p < .10$). Multivariate results, however, revealed that gender, race, history of depression, county of residence and attitudes remained significantly associated with knowledge (See Table 1).

Table 1
Simultaneous regressions models of Knowledge and Attitudes (N=244)

Variable	Knowledge			Attitudes		
	Parameter	SE	t, p	Parameter	SE	t, p
Intercept	6.28	0.60	10.44, ****	15.49	1.74	8.91 ****
Male	-0.76	0.28	-2.69**	0.14	0.77	.18
Of Color	-0.55	0.27	-2.00*	-0.44	0.75	-.59
Physical Abuse	0.22	0.27	0.81 ns			
Physical Neglect	0.00	0.26	0.04 ns			
Sexual Abuse	0.23	0.28	0.82 ns			
History of Depression	0.59	0.27	2.13*	2.20	0.78	2.81**
History of PTSD	0.38	0.31	1.21 ns	0.55	0.86	.64
Live in SW Missouri	0.62	0.31	1.97*			
Past month marijuana	-0.13	0.46	-0.28 ns	-0.65	1.34	-.49
Got drunk past 6 mo	-0.59	0.36	-1.63 ns	-2.04	1.03	-1.97*
Outpatient past year	0.01	0.26	0.02 ns	0.78	0.73	1.08
Group care past year				-1.56	.78	-2.00*
Attitudes	0.07	0.02	3.22**			
Knowledge				.58	0.18	3.20***
Model	F=6.66	p<.0001	R ² = 0.26	F=6.10	p<.0001	R ² = 0.19

+p<.10, *p<.05, **p<.01, ***p<.001, ****p<.0001

Bivariate analysis revealed that gender, race, history of depression and PTSD, past year outpatient therapy use, past year residential treatment use, past substance use and service knowledge were significantly related to attitudes. In the multivariate analysis, service knowledge, got drunk (past six months), past year residential care, and depression remained significantly associated with the ATSPPH scale (see Table 1).

Discussion

When youth transition from care their services drop off; however, their need for services remains. This may be because they themselves do not recognize the need or they have negative attitudes towards services. Older youth have fewer people helping them access services. Therefore, it is critical to understand their knowledge and attitudes. Our data reveal that Caucasians, females, those with a history of depression, and those with more positive attitudes report more knowledge of what to do when faced with a need for services. This suggests that psycho-education modules geared toward transitioning male youth of color may improve their knowledge, attitudes and ultimately their service use.

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Session 17 » 3:45 - 4:45 pm » Salon D

Symposium

Together Facing the Challenge: Preliminary Findings from a Randomized Clinical Trial of Therapeutic Foster Care

Chair: Dannia Southerland

Discussants: Maureen Murray & Elizabeth M.Z. Farmer

This symposium provides the first report on findings from an NIMH-funded randomized clinical trial of therapeutic foster care (TFC) to examine the effectiveness of a training and consultation approach to improving practice and outcomes in "usual care" TFC agencies. The approach draws elements both from Chamberlain's evidence-based model as well as practice-based evidence from existing programs. The intervention, "Together Facing the Challenge," shows improvement (compared to youth in control agencies) on a range of youth-level outcomes. The symposium will provide an overview of the background, intervention, study, and findings. It will conclude with discussion of ongoing analyses on potential mediators of youth-based outcomes.

Together Facing the Challenge – Implementation and Preliminary Findings of a Randomized Clinical Trial of Therapeutic Foster Care

Presenting: Elizabeth M.Z. Farmer & Maureen Murray

Contributing: Barbara J. Burns, Dannia G. Southerland & H. Ryan Wagner

Introduction

This paper discusses implementation and preliminary findings from this randomized clinical trial of Therapeutic Foster Care (TFC). Together Facing the Challenge was implemented with 15 agencies (8 intervention, 7 control) and included 246 treatment foster parents and youth. This portion of the symposium begins with an overview of the background for the study. It includes description of the intervention components and brief discussion of implementing the training. The segment concludes with a report of sample characteristics and findings from the RCT. Overall, the intervention was successfully implemented and youth-level outcomes show significant improvement in symptoms, strengths, and behavior problems for intervention group youth.

Method

Together Facing the Challenge was an NIMH-funded RCT conducted in North Carolina. Fifteen sites (8 intervention, 7 control) were randomized to either experimental or control conditions. Agencies in the experimental condition received: (1) a two-day training for TFC supervisors; (2) a two-hour session per week over six weeks of training for Treatment Parents; (3) monthly consultation for supervisors for one year following the initial training; and (4) booster sessions for Treatment Parents (at 6 and 12 months). Agencies in the control group continued to practice TFC as usual; they also received training when the study was over. Trainings were led by university-based staff but efforts were made

to involve TFC supervisors as co-facilitators and to train lead staff as trainers for sustainability of the intervention. Primary data for the current presentation come from interviews with treatment parents and youth. All data were collected by study-employed research staff for 18 months after the youth/family entered the study (at baseline, 6, 12, and 18 months). Data collection ended in summer 2008 and analyses are ongoing.

Findings

Data show that randomization “worked” to include similar groups in the intervention and control sites. Youth in both conditions had an average age of approximately 13 (range = 2-21) and an average length of stay (at the time of recruitment into the study) of 20 months. Approximately 55% of the youth were African American and 10% were other racial/ethnic minorities. Forty-five percent of youth were female. Treatment Parents were also not significantly different in the two conditions. Treatment Parents had an average age of 48 (range = 22-77), 74% were African American, and 60% were married. We asked to speak to the person who considered themselves the “primary” Treatment Parent for the youth—in 90% of homes, this person was female. Approximately 30% of TFC homes had more than one TFC youth placed in them at the time of study baseline.

Analysis of youth-level outcomes focused on change across time in psychiatric symptoms, behavior problems, and strengths. In both domains, youth in the intervention group showed more positive changes than youth in the control groups. For symptoms (measured by the Strengths and Difficulties Questionnaire), youth in the control group showed no change across time, while youth in the intervention group showed approximately one-third of a standard deviation improvement ($p = .02$). For behavior problems (measured by the Parent Daily Report), youth in the control group showed a slight increase in problems across time, while youth in the intervention group showed a significant improvement ($p = .01$). For strengths (measured by the Behavioral and Emotional Rating Scale), the intervention group showed significantly more improvement in the first six months following training ($p < .01$) but this difference disappeared by the 12 month follow-up.

Measuring Fidelity of Implementation of an Enhanced Model of Therapeutic Foster Care

Presenting: Danna G. Southerland & Elizabeth M.Z. Farmer
Contributing: Maureen Murray & Leyla F. Stambaugh

Introduction

A critical step in the dissemination of an evidence based practice into real world settings is measurement of implementation fidelity (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). We report on the psychometric properties of a fidelity measure, Train the Trainers Fidelity in Therapeutic Foster Care, developed in conjunction with an ongoing randomized controlled trial of Therapeutic Foster Care in a real world setting. Therapeutic Foster Care (TFC), a community-based residential intervention, is an evidence-based treatment for youth with mental health or behavioral problems (Fisher & Chamberlain, 2000). TFC provides intensive individualized treatment within the context of a family and community setting. Trained Foster Parents (Treatment Parents) work with youth in their homes to provide a structured, therapeutic environment. Based on our previous research we developed an enhanced model of long-term TFC, called Together Facing the Challenge: Therapeutic Foster Care in a System of Care. The enhanced model is being tested in a randomized controlled trial in a statewide implementation (Farmer, et al, 2004).

The evidence-based model of TFC builds on behavioral approaches to encouraging positive behavior in youth through parent training, called

Parent Management Training (PMT: Patterson, DeGarmo, & Forgatch, 2004). In the enhanced model, Treatment Parents received training in improving behavior management approaches to more effectively manage their youth's problem behavior. PMT teaches approaches to setting expectations, limit setting, making requests, and encouraging compliance/cooperation. Parents are taught how to use proactive systems to encourage proper behavior and how to react to problems in calm, specific, non-personal ways that encourage appropriate behavior and reduce the risk of escalating power struggles (Pacifi, Chamberlain, & White, 2002).

A train the trainer approach was at the core of the implementation strategy of the enhanced TFC model, and has been described in detail elsewhere (submitted separately for a poster presentation by Maureen Murray et al. at this conference). Supervisors who directly managed Treatment Parents were trained in the enhanced model. Once supervisors were trained, they became part of the training process by assisting in the intensive Parent Management Training. Supervisors received on-going consultation/support from the intervention specialist to address any questions about implementation of the model. In the development of our fidelity measure, we were particularly interested in examining whether there was a training effect demonstrated by enhancement of core components of the parent management training on the intervention site.

Methodology

The fidelity measure was designed to assess fidelity to the key components covered in the training. Based on direct observation during home visits, supervisors were asked to rate the treatment parents ability (using a scale from 0 to 5) to implement the core parenting strategies and techniques covered in the Parent Management Training. During the piloting of this measure we asked for feedback from the supervisors and incorporated their feedback into the revised format.

The data were collected from two of the study agencies, assessing a total of 110 families, during the same one month time period. All supervisors observing families in the intervention sites had participated in the Train the Trainers module of our intervention. The geographic make-up of the sample included several large cities (Raleigh, Charlotte, Greensboro, and Wilmington) and surrounding areas from the central, western, and eastern regions of North Carolina. Psychometrics, factor structure and discriminant validity were examined for the revised fidelity scale, based on ratings from 110 respondents.

Findings

The mean score for the revised scale was 3.26 ($sd = .58$). This suggests the respondents are rating fidelity, on average, in the middle-to-high range and furthermore that the amount of variance in scores was acceptable. We examined the scales reliability by determining Cronbach's alpha of the internal consistency coefficient (ICC). The alpha computed was .95, indicating excellent internal consistency. We also conducted an item analysis to investigate which, if any, items cause the ICC Cronbach's alpha to increase if deleted. This is important to examine because the scale has been revised based on previous piloting. Some items which did not perform well were revised or deleted. Results revealed that no items increased the Cronbach's alpha beyond .95, an improvement over previous versions. The statistical implication of this test is that all of the items are reliably related to the overall construct of fidelity in this scale.

We also performed exploratory factor analysis of the scale, using principle axis factoring and direct oblimin rotation. The KMO value was .93, indicating that the analysis was valid. Examination of the scree plot revealed a sharp drop after the first factor and plateauing thereafter. The eigenvalue for factor 1 was 9.03. Confirmatory factor analysis was then performed using identical specifications, but extracting one factor. Results were identical, confirming that the scale measures one overall domain

(Costello & Osborne, 2005). Based on the presence of acceptable levels of internal consistency revealed by the ICC and high inter-item correlation revealed by the factor analysis, we determined the scale is reliable.

Given these psychometric findings, we proceeded with examining the discriminate validity of the scale, by comparing between group means for the intervention and control agencies. Descriptive analysis revealed that the distribution of the scale for this sample is not normal. Given that the scores are not normally distributed, and there were large sample size differences, we chose to use a non-parametric test in our discriminate validity analysis. Because of the differences in sample sizes we used the Mann-Whitney U test, which tests the null hypothesis that the population means of the two samples are equal, when the two samples are of very different sizes (Nouris, 2003). The mean overall scale score for the control agency was 3.18(.58) and for the intervention agency, it was 3.44(.55). These group means were significantly different (MWU = .931, two-tailed $p = .02$).

Conclusion

Based on these findings, the Train the Trainers Fidelity Scale appears to be a psychometrically sound measure that provides an important tool for assessing the level of implementation fidelity of Therapeutic Foster Care in a real world setting. In our presentation, we will also report on the relationship of the fidelity measure to child and treatment parent process outcomes from the randomized trial.

Session 18 » 3:15 - 3:45 pm » Salon G

Development of a Strength-Based Scale for Use with Preschoolers

Presenting: Michael Epstein

Introduction

Many of the behavior assessment scales used in early childhood special education programs are deficit-oriented. While these scales are helpful in identifying children in need of services, they may not be helpful in developing a child's treatment goals or Individualized Education Plan (IEP). Recently, several parent, professional and policy initiatives have advocated a strength-based approach to assessment. A strength-based orientation views the child and family as individuals with unique talents, skills, and life events as well as having specific unmet needs. Strength-based assessment recognizes that even the most challenging children have strengths and competencies that can be built on when creating a comprehensive plan.

Strength-based assessment, as practiced, has been implemented in an informal fashion by school personnel. This informality has been valuable in furthering the concept of strength assessment, but it also raises serious questions regarding the fidelity of the data collection process (i.e., the consistency of data collection across staff), the reliability and validity of the data, and the value of the data as an educational planning or outcome measure.

Methodology

We began to develop the Preschool Behavioral and Emotional Rating Scale (PreBERS) to provide professionals with a valid and reliable strength-based instrument. The PreBERS is a 42-item scale that identifies preschoolers' behavioral strengths on four dimensions: emotional regulation, school readiness, social confidence and family involvement.

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Each item describes a strength a child may demonstrate (e.g., takes turns in play situations, identifies own feelings). The procedures used to develop the scale are as follows: First, the content validity was established by having several hundred preschool staff identify important strengths, then these individuals rated the items from most to least important, next the items were completed on several hundred children with and without disabilities, and finally the data were factor analyzed to identify the major dimensions of emotional and behavioral strengths.

Findings

These procedures led to the identification of a 42-item, four factor scale. National norms were established on a representative sample of 1,376 children without disabilities. The sample of children without disabilities was representative of children nationwide in terms of geographic region, gender, race/ethnicity, family income, and educational attainment of parents. National samples of children in Head Start ($N = 1,728$) and early childhood special education ($N = 1,675$) samples were also collected. Several validity (convergent) and reliability (test-retest, inter-rater) studies were conducted and found the PreBERS to be a psychometrically sound instrument.

Session 18 » 3:45 - 4:15 pm » Salon G

Head Start, Mental Health, and Integrated Continuous Improvement Processes

Presenting: Christopher Smith, Linda Broyles & Michael Ehlling

Introduction

It is clear that there is a focus on mental health and socio-emotional development in the Head Start Program and Performance Standards (HSPPS) and Child Outcomes Framework (U.S. Department of Health and Human Services: Administration for Children and Families, 2001). Many authors have investigated the value and roles of mental health consultants in the Head Start system (Cohen and Kauffman, 2000), while others have described features common to effective Head Start/mental health collaborations (Yoshikawa and Zigler, 2000). One subset of effective and evidence-based mental health interventions includes Program Wide Positive Behavior Support (PWPBS). Authors have described its use in collaboration with Head Start programs (Frey, Young, Gold, & Trevor, 2008; Hemmeter, Fox, Jack, & Broyles, 2007). While much has been written regarding the implementation of PWPBS, it is often unclear how Head Start and other early childhood agencies can and should integrate this program data with other agency, consumer, staff, and management data as part of a continuous systems-level assessment process (see Smith & Freeman, 2002 for an example of this process).

The partners represented here have been working together in various ways for more than 7 years to develop and implement a number of early childhood mental health programs, and to use program and other data to inform decision-making at the agency and state levels. The University of Kansas (KU) has had a university/Head Start partnership with the Southeast Kansas Community Action Program (SEK-CAP) for over 7 years. SEK-CAP has also worked with local Mental Health Providers to implement local, program-wide positive behavior support (PWPBS). This presentation will focus on the following:

- How SEK-CAP came to initiate its PWPBS project,
- How the local Mental Health providers have collaborated in this effort,
- How the Mental Health providers are working to improve early childhood Mental Health credentialing in Kansas, and
- How the KU/SEK-CAP partnership is focusing on collecting and utilizing Mental Health and all other program and community data for the purposes of program management, continuous systems-level assessment and quality improvement.

Methodology

The KU/SEK-CAP evaluation partnership has utilized a consumer and staff satisfaction survey each year since 2002 to identify issues, trends, and progress. During that time, over 5,000 consumer surveys and more than 1500 staff surveys have been distributed, with most years averaging approximately a 40% return rate (by mail). Consumer surveys have been particularly helpful in identifying the complex ways in which agency services are utilized. Community assessments each year make use of existing community and demographic data to identify potential community and consumer needs. Retrospective quantitative analysis allowed the partners to identify levels of Mental Health funding versus Mental Health referrals over time and measure increases/decreases in each. In addition, retrospective analysis of long-term trends has allowed the partners to identify the impact of PWPBS training on improvements in overall staff satisfaction.

Findings

The following are some of the findings to be discussed:

- Significant reductions in formal Mental Health referrals (from nearly 50 per year to as few as 10).

- Significantly increased use of Mental Health funds for prevention efforts (from as little as 14% to as much as 97% prevention funding last year).
- Significant increases in staff ratings of overall job satisfaction ($p < .01$).
- Local PWPBS early childhood programs achieve nationally recognized Program in Excellence (PIE) status.
- National recognition for SEK-CAP as a community action agency meeting the highest national quality standards.
- In addition, the KU/SEK-CAP evaluation partnership has achieved significant progress in integrating agency-wide data including mental health and other disabilities into the ongoing community assessment, risk management, strategic planning, and daily agency management processes.
- Development of integrated data collection and reporting processes including mental health, disabilities, and other community and consumer needs and outcomes data.
- Significantly improved staff, management, Policy Council, and Board of Directors utilization of program data.
- Development of a state-wide push for early childhood Mental Health credentialing process for Mental Health providers.

Conclusions

The multi-agency collaboration has been productive in creating quality and effective early childhood interventions while increasing staff capacity and satisfaction. The collaborative intervention, and the agency as a whole have both received national recognition for meeting or exceeding quality standards. These findings confirm the importance and potential impact of locally defined and implemented early childhood mental health interventions for children and program staff. In addition, it has become clear to the collaborators that access to high quality program improvement and other data can significantly increase the capacity of an organization to continuously monitor its own risks, successes, and opportunities for growth. The collaborators realize that the roles of mental health consultants as outlined in the Child Mental Health section of the HSPPS (1304.24a), the Family Partnerships section (1304.40), and the Management Systems and Procedures (1304.51) do not fully articulate the potential for local mental health program development and favor process measures rather than outcomes (Frey, Young, Gold, and Trevor, 2008). Finally, the collaborators realize that program implementation, evaluation, and continuous quality improvement are intimately related activities that are not fully appreciated or articulated in the HSPPS or the extant literature.

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Session 18 » 4:15 - 4:45 pm » Salon G

A Complexity Approach to Systems of Care for Early Childhood Mental Health

Presenting: Allison Pinto

Introduction

The theory/science/practice of complexity can potentially improve early childhood mental health in whole communities. This is critical because studies conducted to date suggest that many children are suffering in the first years of life, as rates of diagnosable mental health disorders among young children are comparable to rates among older children (Perry, Kaufmann & Knitzer, 2007), and high rates of early childhood relationship disruptions now characterize communities across the nation (Shonkoff & Phillips, 2000). Large-scale efforts, including systems of care efforts, are now underway in various communities to address early childhood mental health; however, none of these efforts have yet demonstrated community-as-a-whole improvements.

A complexity approach enables us to notice how efforts to improve mental health at various scales interrelate and mutually inform one another. Rather than focusing on the extent to which planned efforts are implemented with fidelity, a complexity approach focuses on that which is emerging naturally in a particular community, through the process of self-organization. This can facilitate an ongoing community reflective process, and might enable a community to increase its potential for “butterfly” effects—tiny innovations that spread and amplify throughout the community in support of early childhood mental health.

Because the emergence of mental health in the first three years of life is an exquisite example of human complexity, developing a complexity perspective on systems of care for early childhood is particularly relevant.

A complexity approach to promoting early childhood mental health at the community scale is now underway through the Children’s Board, which is the county-based Children’s Services Council in Hillsborough County, Florida. A “community learning initiative” is occurring to explore how support is interconnected and exchanged among people and networks throughout the local community in order to support early childhood mental health.

Method

An ongoing community case study is being conducted within Hillsborough County, which involves the following:

- Reviewing existent documentation and local administrative/community datasets relating to the development and well-being of local young children.
- Conducting interviews and participant observation with local young children, caregivers and other service/support providers within homes, programs and networks to better understand the ways in which real-time support is addressing early childhood development.
- Gathering stories from children, parents, child care providers, service providers, and other local community members through the Sensemaker method (Snowden, 2005) about what is making a difference for young children in the local community. Each individual codes their own stories along dimensions of self-organizing. Stories are tracked over time to determine where concerns and innovations are emerging, and to interpret changes as they are occurring.
- Identifying emergent themes through qualitative data analysis software and conducting statistical analyses to identify Pareto distributions indicative of system and community self-organizing (McKelvey, 2007).

A preliminary agent-based model is also being developed to visualize how qualities and actions of local agents and changing features of the environment seem to be mutually influencing one another, resulting in complex patterns relating to the development of young children. The model will be continually revised and refined through processes of group reflection on its goodness of fit with the lived experience of local community members and providers of services and supports.

Results

Findings to date in Hillsborough County reveal that caregivers and service/support providers constantly combine the latest information they have encountered regarding optimal child development with data manifesting in their present lived experience with their children. In moments when they perceive a significant discrepancy between these two types of evidence, they seek “just-in-time” opportunities for sensemaking in order to determine how to address their own children’s development. An individual’s social network, access to technology, embeddedness in community, current affective orientation, and personal history influence perceptions of where the most robust opportunities for sensemaking exist. Sensemaking efforts in turn affect preferences and choices regarding the provision of support for young children.

Caregivers and service/support providers seek out others whom they perceive as knowledge hubs, in order to connect with information that is already somewhat “processed,” so that they might efficiently identify optimal ways of responding to their own children. To the extent that existent knowledge hubs evidence appreciation of the information seeker’s particular circumstances, and respect for the information seeker’s own wisdom and affective state, feedback loops emerge for reciprocal sensemaking. Local knowledge hubs are identified through informal play groups, neighborhood centers, faith communities, and online communities, as well as through formal service systems. Recognition of local patterns is informing the development of relationship-based information and referral systems, case/care management services, and neighborhood centers in Hillsborough County.

Discussion

Findings in Hillsborough County reveal opportunities to become attuned and responsive to the development of young children through more intimate recognition of dynamics emerging locally. This makes it possible for the latest theory and science of child development to reach those particular individuals and groups who are already serving as hubs and trusted connectors in the variety of local social and professional networks through which parents, caregivers and service providers are self-organizing. Synchronizing with patterns of local self-organizing simultaneously enables children, caregivers and the community to contribute to the continued evolution of theory and science, so knowledge can “catch and spread” within and throughout communities. As feedback loops are cultivated through relationships, collective sensemaking is supported. This increases opportunities for informed decision making and actionable knowledge across scales (e.g. child/caregiver, family/neighbor, service provider, program manager, policy maker) and across sectors (e.g. education, safety, health, faith), thereby supporting the healthy mental development of local young children.

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Session 19 » 3:15 - 3:45 pm » Salon H

Understanding the Associations of Child Welfare and Juvenile Justice Involvement of Adults with Severe Mental Illness and Criminal Justice Contacts: A Look Back in Time

Presenting: Diane Haynes, Marion Becker, Ross Andel & John Robst

Contributing: Robert Constantine, John Petrila, Greg Teague & Timothy Boaz

Background

Although there has been a recent surge of research on adult offenders with mental illness, few studies have examined the associations between prior foster care placement, juvenile justice involvement and adult criminal justice contacts. Such studies are essential for the development of interventions that are not only effective but also targeted at the at-risk subgroups, hence conserving resources. Using data obtained from multiple administrative data sources, the goal was to provide new knowledge and a better understanding of the frequency and relevance of prior child welfare and juvenile justice system involvement for adult criminal offenders with severe mental illness.

Methods

This analysis used both statewide and county-specific administrative data sets. Participants were 3,769 adults with serious mental illness identified in the Pinellas County, Florida jail in FY 03-04. In all, 13 data sets from systems providing services to this population were reviewed and utilized to examine the longitudinal pattern of system contacts for the subjects in the study. We reviewed records in the Child Welfare Department (CW); Department of Juvenile Justice (DJJ); Florida County Jails; physical and mental health services (including medication use); Involuntary Baker Act initiations, state mental hospital stays, and homelessness. Data from the Florida Department of Juvenile Justice were available for participants born on or after year 1980 ($n = 509$; 13.5% of the sample). Child welfare data were only available after the year 1996.

Results

Of the 509 participants of which DJJ and CW data was available, 281 interacted with DJJ only, 94 interacted with both DJJ and CW, and 134 had no record in DJJ and CW. When compared to those who interacted with both DJJ and CW and those with no interaction, those who interacted with DJJ only were more likely to be male, African American, and have Schizophrenia or delusional/other disorder.

With respect to the type of system interactions, a greater proportion of those interacting with the DJJ only were involved in the adult prison system (12.81%) compared to those who interacted with CW and DJJ (10.64%) and those who had no interaction with CW or DJJ (6.72%). They also had fewer interactions with the County Health and Human Service system (5.69%) compared to those in contact with DJJ and CW (26.60%); and no contact with CW/DJJ (21.64%). In addition, more

than twice as many of those who interacted with DJJ only were homeless at some point in their adult lives (10.68%), CW only (4.26%), and no CW/DJJ (3.73%).

More of those who interacted with both CW and DJJ also interacted with the Medicaid system as adults (53.19%), than the other 2 groups (DJJ only, 38.79%; no CW/DJJ, 21.64%). Of those 94 who interacted with the Child Welfare System, 7 were removed from their families; all had multiple reports of abuse; and 17.20% had founded sexual abuse.

As adults, the overall total cost for mental/physical health, social service, EMS, and criminal justice across the 4 years of the study were \$12,983.97 per individuals who had interactions with DJJ only as youths compared to \$10,430.53 for those who had Child Welfare Interactions and \$6,413.77 for those who did not have any DJJ or Child Welfare interactions as youths.

Conclusions

This study found that of the 509 adults born on or after year 1980, 70% had previous interaction with the juvenile criminal justice system as youths, agreeing with a recent report that found 78% of the adults in the Pinellas County Jail who were 21 years of age or younger had interacted with the juvenile criminal justice system as youths (http://psrdc.fmhi.usf.edu/Pinellas/Juv_CJIS%20MEMORANDUM.pdf). Overall system interactions (involuntary Baker Act Initiations, Health & Human Services, Medicaid, State Mental Hospital, and EMS) were higher, for those who had prior Child Welfare involvement, which may suggest that early intervention and/or interaction with social and health services systems as youths increase the likelihood of accessing needed services as adults.

Policy Implications and Directions for Future Research

Among the mentally ill, many of the individuals with criminal justice encounters also had encounters with the juvenile justice and child welfare systems. This suggests an opportunity for intervention for youths with mental illness who have DJJ and CW contacts. Treatment may be a cost effective option for the public sector given the high costs of criminal justice encounters, particularly those that result in placement in prison.

Future research might examine a sample of youth in the juvenile justice system and determine the relationship between mental illness and adult criminal justice contacts. Such an analysis would determine whether mentally ill youth with juvenile justice encounters are more likely to also have adult encounters, or whether all youth with juvenile justice encounters are likely to have adult criminal justice contacts. In addition, such a study could also determine whether the amount of behavioral health treatment is related to the likelihood of adult criminal justice contacts.

Session 19 » 3:45 - 4:15 pm » Salon H

Bridging the Gap between Community Mental Health and Juvenile Justice Systems

Presenting: Stephen Kapp, Mary Lee Robbins & J. J. Choi

Introduction

The purpose of this study is to understand the impact of a state's decentralized public mental health (MH) and juvenile justice (JJ) systems on interagency partnership and collaboration at the local community level with the intention of improving service delivery to youth and families. Underscoring the need for our study of cross-system collaboration are recent studies suggesting that the rates of MH disorder can reach as high as 70% among youth in the JJ system, two to three times higher than among youth in the general population, with 20% of these youth having severe symptoms (Shufelt & Coccozza, 2006). Studies also found a lack of MH services for court-involved youth, an overloaded JJ system which gets these youth by "default," and that youth with mental health service needs have not been consistently identified and effectively served (Skowrya & Coccozza, 2007). This often results in: (a) ineffective or no interventions for youth; (b) failure to improve the quality of youth's lives; (c) harmful effects caused by overuse of incarceration and out-of-home placements; (d) failure to reduce recidivism rates, and; (e) jeopardized public health and safety. However, studies also indicate that consistent collaboration between MH and JJ systems improves the long-term outcomes for youth.

Our primary research goal was to learn from consumers and professionals about how dual-system collaboration occurred for them at the direct service levels and what they needed to maintain or improve collaboration.

Methodology

Researchers conducted 72 semi-structured interviews with 18 youth and 54 stakeholders comprised of parents, and both mental health and juvenile justice professionals in the youth's life from five Community Mental Health Centers (CMHCs) and overlapping judicial districts. CMHCs included a representative range of community sizes, from rural to urban.

First, researchers utilized ATLAS.ti qualitative analysis software to identify common themes. A Grounded Theory approach provided a foundation for open, focused, and axial coding. Second, researchers developed Unit Summaries, a form of plot summaries we devised from the transcripts to understand the chronology and complexities of each youth's experiences with these dual systems. Each of the 18 Unit Summaries, derived from the previously mentioned four perspectives, represented a systematic overview of the youth's history and challenges with being involved in these systems. We defined "collaboration" and "youth outcome" criteria to determine whether evidence of collaboration existed and linked collaboration to positive, mixed, or negative outcomes. We linked collaboration evidence with the number of out-of-home placements to determine severity and then compared those results with collaboration determination.

Findings

Analyses yielded a critical finding related to the association between the existence of collaboration and the effectiveness of dual-system services. Participants identified a wide range of differences in collaboration

within and across these systems. For example, in areas where working relationships developed between individual professionals over time, there existed a higher level of collaboration. Participants also provided information about philosophical differences between mental health and juvenile justice systems, barriers to collaboration, and suggestions for improvement. In areas of high staff turnover, collaboration became more difficult or nonexistent. While some effective collaboration occurred idiosyncratically or informally at the direct contact level, this finding did not carry over into corresponding policies and procedures.

As a result of our content analysis and Unit Summary analyses, we found the existence of a positive relationship between collaboration and outcomes. In general, when collaboration was high between the two systems, youth outcome also tended to be positive. However, we also found a breakdown of collaboration and services when youth were in crisis, especially during transitions to and from out-of-home placements.

Conclusion

These important findings exemplified the need for improved collaborative strategies by bridging the gap between the two systems via specific formal and informal collaborative policies, procedures, programs and practices, especially at the local level. In the final phase of this study, researchers funded pilot grants for two CMHCs that demonstrated the need for readiness to undertake the challenge of improving cross-agency collaboration.

After only one year of these two-year grants, CMHCs have already experienced substantial progress. Under the competent leadership of highly motivated staff, both CMHCs independently focused on improving their juvenile intake and assessment process and their MH referral systems; their efforts have tightened collaboration and partnering between the MH and JJ systems and enabled many court-involved youth to receive immediate MH services that would have otherwise not occurred. Applying research findings at this local level has far-reaching implications by improving outcomes for high risk youth by maintaining them in their communities, reducing recidivism, and eliminating unnecessary human suffering.

The MH and JJ systems will also benefit by reducing the number of detained youth in an already over-burdened JJ system and provide MH professionals with a way to strengthen their collaborative efforts with JJ professionals in a formal, systemic and sustainable way.

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Session 19 » 4:15 - 4:45 pm » Salon H

Evaluating Project Connect: Training on Mental Health Linkage for Juvenile Probation Officers

Presenting: Gail Wasserman & Larkin McReynolds

Juvenile probation settings are under-utilized public health locations in which to evaluate youth and link them to appropriate mental health services. Probation officers function as “gatekeepers”, linking youth to a range of mental health and other services. Despite the large number of youths, their elevated risk, and their characteristically low rate of prior mental health service access, procedures for identifying mental health needs in youths undergoing juvenile probations intake have rarely been examined. Recent models of referral decision-making that consider characteristics of youths and gatekeepers have highlighted the critical role of gatekeepers’ inservice and professional training (Stiffman et al., 2000).

In order to target probation practices that relate to enhanced mental health identification and linkage to community service providers, we developed and evaluated a multilayered county-specific suicide prevention program for youth in juvenile probation in four NY counties. Program goals included enhanced identification of suicide risk and increased linkage of youths with mental health needs to community providers. The intervention was designed to include four components: (1) informal cooperative agreements between each county’s probation and mental health authorities, (2) program materials to facilitate referral, (3) systematic screening of mental health needs, and (4) in-service training for probation gatekeepers. Among the relatively few youths who agreed to screening, those who were Screen-positive were intended to receive a pre-determined set of probation practices. Accordingly, we confine our analysis here to Baseline and Non-screened Intervention youths.

Before beginning our intervention, for 3.5 months, we systematically reviewed case records for 583 juvenile delinquency intakes. Biweekly, project staff reviewed probation records, noting practices related to mental health identification and linkage, including service recommendations and inter-agency contact; 14% were receiving mental health or substance

use services at case opening, and 25% were newly identified during probation contact. Based on logistic regression, youths were significantly more likely to be newly identified if they were repeat offenders ($p < .01$), if their probation officer knew more about mental health ($p < .01$) and if they resided in a county without a shortage of available mental health professionals ($p < .001$). Altogether, this model explained 42.3% of the outcome variance. Probation officers were especially likely to under-identify internalizing disorders and suicide risk.

We compared practices for the 583 Baseline youths with those for the 501 Intervention youths. Compared to Baseline, during Intervention, POs engaged in certain practices more likely to promote service access: they were significantly more likely to call the provider to make the referral themselves (67.2% vs 42.0%; $\chi^2(1) = 17.91, p < .001$); during Intervention, POs were significantly less likely to make referrals for services other than to MH/SU treatment programs (29.7% vs 16.2%; $\chi^2(1) = 27.40, p < 0.001$). During Intervention, POs’ were significantly more likely to confirm service initiation for those youths who were already in treatment at case opening or who received a new referral [59.3% vs 46.4%; $\chi^2(1) = 6.04, p < .02$]. Service access was more than twice as likely in Intervention than in Baseline youths (OR = 2.58, 95% CI = 1.32-5.04, $p < .01$), even adjusting for youth demographics and offense characteristics, for the number of weeks a youth’s chart was open for review and for the availability of mental health professionals in that county. Altogether these measures explained 25.9% of the outcome variance in new referrals.

Project Connect increased mental health access for juvenile probation youth via changes in specific probation practices related to interagency communication. In-service training, establishing clear referral protocols, and greater inter-agency collaboration helps probation agencies better address the unmet mental health/substance use (MH/SU) needs of this vulnerable population.

Session 20 » 3:15 - 3:45 pm » Salon I

Emergency Commitment of Young Children

Presenting: Annette Christy & Brittany Haldeman

Introduction

Currently, about one in five children in the United States have a mental disorder. One in every 200 preschoolers receives treatment for a mental health disorder (New Freedom Commission, 2003). The prevalence rate of young children with a mild to moderate behavioral problem is estimated to be 10 to 15%. Among preschool children, 21% are estimated to have a diagnosable disorder, with 9% having a severe disorder. Of toddlers and preschoolers diagnosed with a disruptive disorder, 50% continue to exhibit problem behaviors into the school years (Powell, Dunlap, & Fox, 2005). Although there has been an increased awareness about such disorders among preschool aged children, the mental health system has failed to recognize the disorders in many of these young children. Children often exhibit emotional and behavioral problems in preschool but these disorders are not recognized until they reach elementary school (Knapp, et al., 2007).

It is estimated that currently 6-9 million children are not getting help for their mental disorders. There are several barriers in the mental health system that prevent children and adolescents from receiving the mental health care they need. Many communities do not provide adequate services for children and their families. Primary care and school settings often fail to recognize mental disorders in children. This can lead parents

to turn to emergency care when a situation arises. Unfortunately, emergency services often do not provide adequate evaluations on children. Instead, these children and adolescents are sent home and referred to local mental health services. Mental health care in schools can be an effective venue by which to provide long term treatment for children. However, less than 10% of schools have a complete range of services that include assessment, treatment, prevention and case management (Baren et al., 2008). Many children enter the mental health system during a time of crisis (Walter, Petr, & Davis, 2006). Crisis services are an important way to address the mental health needs of children. Very little is known about the use of emergency commitment (EC) for young children. The purpose of this study is to investigate the use of EC (known in Florida as a Baker Act examination) for young children (ages 5 through 10).

Method

Data for ECs for the three year period from January 2005 through December 2007 were used for these analyses. These data are received by the Baker Act Reporting Center from receiving facilities statewide (see Christy, Kutash & Stiles, 2006 for more detail) There were 359,578 ECs during this time period, of which 6,432 (2%) were for young children. ECs occurred at the following ages: 5 ($n = 245$; 4%); 6 ($n = 566$; 9%); 7 ($n = 899$; 14%); 8 ($n = 1,248$; 19%); 9 ($n = 1,552$; 24%); and 10 ($n = 1,922$; 30%). Three quarters (76%) of these ECs were for boys, with 34% for girls.

Results

Fifty nine percent ($n = 3,787$) of these ECs were initiated by law enforcement, with 40% ($n = 2,590$) initiated by mental health professionals, and 1% ($n = 55$) by judges. The majority of ECs were based on evidence of harm ($n = 5,489$; 85%), with ECs also based on both harm and neglect ($n = 529$; 8%), and neglect only ($n = 259$; 4%). While three quarters of young children experienced only one EC during this time period ($n = 2,673$; 74.9%—counting only ECs that occurred while the child was between 5 and 10), some children experienced several, including those with two ($n = 510$; 14.3%); three, ($n = 186$; 5.2%); four ($n = 78$; 2.2%); five ($n = 45$; 1.3%); six ($n = 35$; 1.0%); seven ($n = 17$; 0.5%); eight ($n = 9$); nine ($n = 6$); ten ($n = 5$); two children with 11, 13, and 14 ECs, and; one child with 16 ECs.

Discussion

While young children account for a relatively small percentage of ECs, there are a meaningful number of young children with ECs. The children with multiple ECs are a group particularly in need of further study. Our research team is currently applying Global Information System (GIS) analysis to investigate this issue in order to understand the geographic distribution (e.g., by zip code of residence and county) of ECs for young children and how they relate to various factors (location of receiving facilities for children, population of children, socio economic status, etc.). The results presented here and these GIS findings will be discussed with reference to policy related to mental health services for young children.

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Session 20 » 3:45 - 4:15 pm » Salon I

Length of Pediatric Mental Health Emergency Department Visits in the United States

Presenting: Brady Case

Contributing: Sarah Case, Mark Olsson & James Linakis

Introduction

There is growing concern over delays in the emergency mental health treatment of youth living in the United States. Individual health professionals, medical associations, state health agencies, and the U.S. Surgeon General have expressed concern that critical shortages of inpatient and outpatient mental health services force children and adolescents to seek care in emergency departments. While studies of individual emergency departments suggest pediatric visits for mental illness are markedly longer than for other disorders, no national data are available. In the current study, we compared mental health to other pediatric emergency department visits focusing on length of stay and identified predictors of prolonged mental health visits.

Methodology

Data were analyzed from the National Hospital Ambulatory Medical Care Survey, a nationally representative annual sample of approximately 40,000 U.S. emergency department visits conducted by the National Center for Health Statistics. Patients aged 18 years and younger who visited an emergency department in the United States between 2001-2006 with a principal diagnosis of a mental disorder ($N = 1,140$) or other illness ($N = 55,363$).

Annual population-adjusted rates of emergency department mental visits were calculated as weighted annual means using annual U.S. Census Bureau estimates for civilian non-institutionalized residents aged ≤ 18 years. Mental health visits were compared to other visits with regard to patient and hospital characteristics, treatment, and length of stay using Bonferroni-adjusted χ^2 tests. The effect of a mental health diagnosis on emergency department length of stay was modeled in backwards multivariate linear regression analysis controlling for all other significant background predictors. Predictors of prolonged mental health visits were similarly identified in two additional multivariate analyses controlling for background and treatment characteristics.

Findings

Mental health visits were more likely than other visits to arrive by ambulance (21.3% vs. 6.5%, $p < .001$), be triaged to rapid evaluation (26.2% vs. 15.2%, $p < .01$), and be admitted or transferred (28.4% vs. 6.3%, $p < .001$). Mean length of stay for mental health visits was 239 minutes, which exceeded the duration of other visits by 91 minutes (95% confidence interval [CI] 52-130) or 62%, and the difference remained significant after controlling for other patient and hospital characteristics. Differences were greatest for the privately insured (113 minutes, 95% CI 63-164), for those administered medication (141 minutes, 95% CI 30-252), and in the Northeast and South (127 minutes, 95% CI 80-174 and 136 minutes, 95% CI 35-238). Among mental health visits, location in the Northeast or South, private insurance payer, weekday arrival, and the presence of a comorbid mental illness diagnosis all predicted longer stays.

Conclusions

Pediatric mental health visits present a difficult challenge for U.S. emergency departments. Compared to other pediatric emergency visits, mental health visits are longer, more acute, and more likely to result in inpatient admission. The extent to which individual youth with mental health disorders place demands on emergency services varies by patient age, ethnicity, insurance status, day of visit, and hospital location. At a time when emergency department overcrowding is a major public health concern, youth with mental health disorders experience prolonged waits for assessment and disposition. After a decade of marked constriction in use of pediatric inpatient mental health care and persisting concerns over access to outpatient mental health treatment, emergency department providers face the sometimes challenging task of finding inpatient beds for more than one-quarter of youth who present with mental health disorders. Our findings suggest areas for administrative and clinical reform.

Session 20 » 4:15 - 4:45 pm » Salon I

Out-of-Home Placement Following a Psychiatric Crisis Episode among Children and Youth

Presenting: Jung Min Park

Contributing: Gary McClelland

Introduction

National and regional studies report that the prevalence rate of serious emotional and behavioral problems among children in the child welfare system is in a range between 42-60%. The extent to which children with mental health treatment are at risk for out-of-home placement, is less known. This longitudinal study followed a cohort of children and youth who were referred to psychiatric crisis screening and services in order to determine the probability and associated factors of subsequent out-of-home placement among children and adolescents in a psychiatric crisis episode. The current study has implications for identifying the timing of out-of-home placement among children and youth in psychiatric crisis and developing enhanced intervention strategies to reduce risk for parent-child separation and for out-of-home placement.

Methodology

The current study was conducted using two sources of data: (1) records from the Screening, Assessment and Support Services (SASS), which provide psychiatric crisis screening and services to children who are at risk for psychiatric hospitalization. All Medicaid-eligible or uninsured children and youth are eligible for the SASS. The SASS records include children's psychiatric conditions, disposition of screening, date of services, and demographic characteristics; and (2) child welfare records from the Illinois Department of Children and Family Services.

The sample included 14,580 children and adolescents under 18 years of age who were referred to psychiatric crisis screening and services between January 1, 2006 and December 31, 2006 and who were not in out-of-home care at the time of the SASS screening.

Psychiatric conditions of the sample were measured during the crisis screening through a standardized assessment tool with a 27-item Likert-type rating scale for five impairment categories of psychiatric symptoms: risk behaviors, level of functioning, co-morbidity, and system factors. Type of treatment was categorized as hospitalization and community-based treatment. Demographic characteristics included race and ethnicity,

sex, age, and region. Placement in out-of-home care was measured by a child's placement in the custody of child welfare agency and receiving out-of-home care in a foster home, group home, or residential institution.

Chi-square and *t*-tests were used to explore the bivariate relationships between covariates and out-of-home placement. Logistic regression was used to examine the effects of covariates on out-of-home placement.

Findings

Of 14,580 children and youth in the sample, 449 (3.1%) were subsequently placed in out-of-home care through the child welfare system. These children accounted for approximately 20% of those who first entered out-of-home care. For the 449 children and youth placed in out-of-home care, the median time between the first SASS contact and out-of-home placement was 266 days, the 75th percentile was 443 days, and the 95th percentile was 640 days.

Of the remaining 14,131 children and youth who were not placed in out-of-home care either prior or subsequent to SASS screening, 1,283 (9.1%) had prior involvement with the child welfare system that did not result in parent's losing custody of their child. Of these 14,131 individuals, 147 (1.1%) subsequently received child protective services without out-of-home placement.

The results of relative hazards of entry into child welfare show that preschool-aged children were at greater risk of entry into child welfare, followed by the teenage group.

Conclusion

The findings suggest that children in a psychiatric crisis episode—particularly certain subgroups—are at high risk for placement in out-of-home care. These children in particular may benefit from integration between mental health and child welfare systems and continued follow-up, not just with the child, but with their families to reduce the risk of out-of-home placements. Costs associated with these interventions would be offset by the considerable public costs associated with placement in the child welfare system.

Spreading and Sustaining Best Practices through the Learning Collaborative Model

Chair: Charles H. Seagle

Discussant: Larke N. Huang

Successful integration of evidence-based practices into systems of care involves addressing the role of service systems in evidence-based practice implementation, the social context into which the practice is being introduced, the likelihood for conflict and competition with existing practices, and the strengthening of existing modes of communication among system components (Israel, Hodges, Ferreira, & Mazza, 2007). To address these factors within the child-serving systems of the National Child Traumatic Stress Network (NCTSN), the National Center on Child Traumatic Stress has uniquely integrated mental health practice implementation principles with clinical trauma intervention training expertise in the form of "Learning Collaboratives (LC) on Adoption & Implementation of Mental Health Evidence-Based Practice." The National Center for Child Traumatic Stress (NCCTS) has established an approach that focuses on spreading, adopting, and adapting best practices in mental health across multiple settings, and on creating changes in organizations that promote the uptake and delivery of effective interventions and services. The ultimate goal of the LC approach is to provide high-quality training in best practices of trauma-focused treatments in diverse settings—including NCTSN sites and their local communities—and to ensure the sustained use of those practices. This symposium brings together the developers of this Learning Collaborative model and researchers from the NCCTN cross-site evaluation in order to describe the LC model and its development, the implementation of the LC approach within the NCTSN and a System of Care community, and the significance of the LC model for supporting the implementation of Trauma-Focused Cognitive-Behavior Therapy, Child-Parent Psychotherapy, and other EBP's.

The NCCTS Learning Collaborative Model for the Adoption and Implementation of Mental Health Evidence-Based Practice

Jan M. Markiewicz & Lisa Amaya-Jackson

Contributing: Lori Ebert, John Fairbank & Jenifer Maze

Introduction

A large gap exists between best practices for child mental health treatment and what is practiced in many community agencies. The NCCTS Learning Collaborative Model on adoption and implementation of mental health evidence based practice was developed to address this gap. This paper will provide an overview of the model, essential elements, and select evaluation findings.

Methodology

History & Development of Model. Building on collaborations with the Institute for Healthcare Improvement on their Breakthrough Series model, Casey Family Programs, founders of the National Initiative for Children's Healthcare Quality, and the Center for Children's Healthcare Improvement, around the implementation science of adopting evidence-based treatments in healthcare and application of quality improvement strategies, the SAMHSA-funded NCCTS has integrated mental health practice implementation principles with clinical trauma intervention training expertise in the form of "Learning Collaboratives (LC) on Adoption & Implementation of Evidence-Based Practice." The NCCTS LC model emphasizes focused enhancement of clinical competence in an evidence-based treatment as well as training in methods designed to help participating agencies/practitioners fully implement and sustain

the practice. In 2006 the NCCTS was the first to conduct a Breakthrough Series Collaborative (BSC) in mental health when it conducted its "National BSC on the Adoption and Implementation of Trauma-Focused CBT," funded by SAMHSA (Agosti et al. 2007). The LC model has evolved utilizing lessons learned from each one conducted (Markiewicz et al. 2006); NCCTS has conducted 17 Learning Collaborative on evidence-based treatments. LCs provide a venue in the application of EBTs for clinicians and supervisors to tackle difficult community implementation issues, including the balance between fidelity and individual client needs for flexible adaptation. (Amaya-Jackson & DeRosa, 2007).

First BSC in Mental Health on Adopting & Implementing TF-CBT

Participants/Duration. 12 community Mental Health Agencies Teams (120 participants) were selected through an application process. The agencies included clinic-based, hospital-based, urban, and rural sites from across the country. Agency teams were comprised of 6-10 individuals. The BSC Learning Collaborative lasted 9 months.

Model Description

The following 5 key aspects of the BSC methodology were applied in this effort:

The Model for Improvement is based on the idea that *all improvement requires change, but not all change results in improvement.*

The following strategies were utilized to affect and measure progress:

- **Plan-Do-Study-Act Cycles (PDSAs).** Used to rapidly execute small tests of change.
- **Monthly Metrics.** Metrics are collected by participating sites on a monthly basis and include measures of progress toward Collaborative goals.

The NCCTS Improvement Advisory Team directs and charts the overall course of the Collaborative, providing coaching to faculty and participating organizational teams.

Faculty, selected based on expertise, included experienced clinicians and supervisors in TF-CBT, agency administrators with a background in implementing child trauma practices, family members with firsthand experience with TF-CBT, and community partners.

Participating Agency Teams included a high-level administrator, supervisors and clinicians, with roles considered critical to the process of adopting the intervention. Sites were encouraged to include family members/community partners.

Collaborative Learning Environment is central to the success of the BSC. Collaboration within and across teams is one of the primary reasons that changes can be tested, implemented, and spread so quickly. The components used to create this include:

- **Learning Sessions.** During three, two-day Learning Sessions teams received in-person training in improvement methods, addressed practice, reported on their progress and lessons learned, and did problem solving with their colleagues from other sites.
- **Affinity Group Calls, Supervisor Calls, and Cluster Calls** included (1) consultation on the treatment model to build clinical competence and supervisory capacity, (2) discussions of topics related to implementing TF-CBT in diverse settings (e.g., cultural competence, family engagement). Calls targeted for specific Affinity Groups (e.g., administrators, clinicians, supervisors) focused on challenges and strategies around implementing the practice pertinent to their particular roles.

- *Intranet* was an interactive, password-protected website to facilitate sharing resources, engaging in online discussions, and posting monthly metrics and PDSAs.

Evaluation (two phases):

The formative evaluation examined implementation of TF-CBT over the course of the collaborative as well as use and perceived utility of the BSC methodology. The purpose of the follow-up survey was to evaluate the extent to which participating agencies were able to sustain and spread skillful delivery of TF-CBT subsequent to the collaborative.

I. Formative Evaluation done using (a) Questionnaires assessing use of BSC for adoption of TF-CBT, (b) 9 Focus Groups conducted during Learning Session 3 and (c) Interviews with faculty and improvement team

II. 18 month follow-up via Web based survey done October-December, 2007.

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“What Are We Going to Need to Implement This?” Disseminating the Learning Collaborative Methodology in Four States

Presenting: Charles Seagle

Contributing: Elizabeth Douglas, John Gilford & Adrienne Pica

Introduction

To facilitate the implementation and sustainability of effective practices for treating child traumatic stress, the SAMHSA-funded National Child Traumatic Stress Network (NCTSN) developed the Learning Collaborative method. Learning Collaboratives (LCs) support the implementation of evidence-based practices (EBPs) by simultaneously introducing one new clinical practice, and relatively quickly planning and implementing the myriad organizational changes to support the sustainability of that practice. Four NCTSN centers implemented the LC model in ways quite similar to the developers' approach, but adapted it to their own particular challenges and goals.

As part of the cross-site evaluation of the SAMHSA-funded National Child Traumatic Stress Initiative, the authors conducted a qualitative study on adoption and implementation, which included a set of interviews with people from NCTSN centers in North Carolina, South Carolina, and Mississippi who developed LCs to support the spread of TF-CBT throughout each state. In a fourth NCTSN center, located within a larger hospital system in San Diego, California, clinicians already trained in PCIT developed an LC in order to better serve younger children affected by trauma. Each center drew on local and national resources to address the need for high quality services for children affected by trauma, and adapted the LC approach in unique ways to achieve their goals.

Methods

Data for this paper have been drawn primarily from guided, retrospective interviews with 20 key individuals involved with the development, dissemination, and implementation of the LC model. These interviews were conducted with LC developers and participants in 2007 and with LC organizers in 2008 by qualitative researchers from Macro International Inc. and Walter R. McDonald, Associates as part of the Cross-Site Evaluation of the National Child Traumatic Stress Initiative. Most interviews lasted about an hour. Some were conducted in person while others were conducted over the telephone. Open-ended questions led to the elicitation of extended narratives about respondents' experiences developing, disseminating, planning, and implementing LCs.

Interview recordings were transcribed, and data were analyzed using the software package Atlas.ti 5.2.17. The first phase of analysis involved a data inventory, in which multiple passes through interview transcripts led to the identification of emerging themes, followed by the selection and categorization of text to organize responses according to themes. The initial categories were developed by trained analysts from Macro International Inc. and were based on the study's research questions, the interview guides, and the preliminary data inventory. In the second phase of analysis, the segments of text aligned with each general theme were compiled and responses were examined within categories, which resulted in a refined set of thematic arguments about the data, which were then substantiated through additional review of the data.

Findings

While LC organizers and developers were sanguine about their opinion that LCs are not for everyone, they expressed few doubts that LCs helped spread highly effective practices with promising levels of fidelity and sustainability. Every respondent, including those who were very skeptical at first, recommended the LC approach overall. LCs helped make routine and generalized processes that were supportive of effective clinical practice, such as sharing ideas with other clinicians, monitoring the application of clinical techniques, and disseminating information about services and child traumatic stress throughout the community.

LC organizers issued specific recommendations about how best to approach LC implementation, based on their own experiences experimenting with the model. Respondents recommended:

- obtaining high levels of commitment from clinicians and agencies, especially from supervisors and senior leaders, or else they will not be able to sustain effective practices;
- providing adequate explanations of what LCs are and how they are different from other forms of training; and
- attending to the distinct needs of different kinds of participants.

Each of these recommendations was based on LC organizers' actual successes and challenges both as participants and leaders in multiple LCs. As the researchers learned in the interviews with LC developers and participants, this is an evolving model promoting and subject to a process of continuous learning and quality improvement. In each setting, LC organizers innovated and adapted the model to maximize the uptake of TF-CBT and other EBPs based on local conditions. In Mississippi, LC organizers established a mentoring system and a supervisory learning session that would help supervisors support clinicians in a new model they were learning themselves for the first time. In North Carolina, LC organizers established peer supervision groups, since most of the clinicians were in private practice and did not receive agency-based supervision. Other innovations in California and South Carolina reflected significant local challenges LC organizers were attempting to overcome.

Conclusions

LCs supported the introduction of evidence-based treatments, but perhaps more importantly, they support the fidelity and sustainability of these practices. One of our respondents noted that *“In order to continue doing that practice in their agency, [LC participants] have to have some examination of what’s been the past history... of taking a new practice and putting it into place in the agency. And I think that’s the unique thing about LCs that helps people along.”* Learning from past experience, LC participants can be uniquely positioned to support quality improvement based on the actual conditions and experiences of their agency. For that reason, among others to be highlighted, this discussion of the development, dissemination, and implementation of the LC model can instruct system of care grantee communities in a method for supporting the implementation of evidence-based children’s mental health practices.

Applying the Learning Collaborative Methodology to System of Care Practice—Alamance Alliance

Presenting: Jan M. Markiewicz

Contributing: Robert Murphy, Lisa Amaya-Jackson, John Fairbank, Lori Ebert, & Susan Osborne

Introduction

The National Center for Child Traumatic Stress (NCCTS) Learning Collaborative (LC) Model is an integrated training and quality improvement process designed to spread best practices across multiple settings. Topics selected for learning collaboratives emphasize closing the gap between “what we know and what we do” (i.e. best practice and usual practice).

The Alamance Alliance for Children and Families (AACF), recently funded through a cooperative agreement with SAMHSA, will be utilizing this methodology to promote the successful adoption of wraparound practice and targeted early childhood clinical interventions over the course of the grant. AACF will promote the mental health and social and emotional well-being of children ages 0-5 with serious mental health needs and their families by developing a comprehensive early childhood SOC.

Methods

The LC model will provide the framework for disseminating and promoting the successful adoption of practices that will benefit young children and their families. Through this process, the *Alliance* will spread and embed SOC practices, wraparound strategies, other evidence-based early childhood interventions and family support approaches within services, programs, and policies of agencies and organizations that touch the lives of young children and their families.

The LC methodology has been adapted from the Institute for Healthcare Improvement’s Breakthrough Series Collaborative (BSC) and subsequently used in the child welfare field by Casey Family Programs. It is a quality improvement methodology focused on adopting, adapting, and spreading best practices across multiple settings and creating the organizational changes necessary for practices to take hold. The LC includes extensive training in an evidence-based practice (EBP) and a vital focus on engaging an entire organization in the change process—senior leaders, supervisors, community partners, consumers, and direct service providers. Practice adaptations are made systematically to ensure core components of the practice are being modified and strengthened to meet the unique needs of the people being served. Participants receive training in methods designed to help them fully implement, spread, and sustain the practice.

AACF will use the LC method to simultaneously improve standards of mental health interventions and wraparound best practices for the target population. By fully integrating SOC principles and values through the LC method, it will ensure that EBPs are implemented with fidelity, sustained, and delivered in a manner fully responsive to the strengths and needs of children and their families, cultures and communities. Implementation of this LC methodology will spread and embed SOC, wraparound, early childhood EBPs and family support strategies within services, programs, and policies of agencies and organizations that touch the lives of young children and their families. The *Alliance* will marshal the expertise of families, youth, professionals, and community partners to develop and sustain these improvements within a SOC that embraces culturally competent, family driven and youth-guided services and supports. As a result, AACF will assist families, the primary source of strength and support for their children, in their efforts to help their children be safe, emotionally and physically healthy, and ready for school (Alamance County Department of Social Services, 2008).

Monday, March 2 » 5:00 pm

Session 22 Salon A-B	Symposium—Community Mobilization toward Evidence Based Practice: Implementation and Testing of Two Strategies in Washington State <i>Chair: Eric J. Bruns</i> <i>Discussant: Robert M. Friedman</i> Partnerships for Success in Washington State: An Example of a Community-Based Model to Effectively Implement Evidence-Based Practices for Youth <i>Suzanne E. Kerns, Eric J. Bruns, Eric W. Trupin & Gary Enns</i> Project Focus: Effective Mental Health Practices for Washington's Foster Children <i>Shannon Dorsey, Suzanne E. Kerns, Kenyatta Etchison & Eric Trupin</i>	Page 111
Session 23 Salon C	Topical Discussion—From Principles to Practice: System of Care Program Installation and Governance <i>Rosalyn Bertram, Janis Bane, Stephen Williams & Rebecca Johansson</i>	Page 114
Session 24 Salon D	Topical Discussion—Methodological Considerations in Evaluating Preschool Risk, Resilience, and Trauma: In and Out of Child Welfare <i>Adam G. Stein, Erin Stettler, Susan Chinitz & Peter Pecora</i>	Page 115
Session 25 Salon G	The Impact of Family Education and Support Services in System of Care Communities <i>Phyllis Gyamfi</i> Reducing Stress and Employment Loss for Parents Caring for Children with Mental Health Disorders <i>Eileen Brennan</i>	Page 116 Page 117
Session 26 Salon H	Topical Discussion—Critical Success Factors to Achieve Family-Driven, Youth- Guided System Planning <i>Myra Alfreds, Carol Hardesty, Candy Kennedy & John Ferrone</i>	Page 118
Session 27 Salon I	The National Behavior Research and Coordination Center: Overview and Final Findings <i>W. Carl Sumi, Michelle Woodbridge & Mary Wagner</i>	Page 120
Session 28 Salon J	Symposium—2008 Honoring Excellence in Evaluation (HEE) Event: Recipients Share their Work <i>Chair: Sylvia K. Fisher</i> <i>Discussant: Laura Whalen</i>	Page 121

Session 22 » 5:00 - 6:00 pm » Salon A-B

Symposium

Community Mobilization toward Evidence Based Practice: Implementation and Testing of Two Strategies in Washington State

Chair: Eric J. Bruns

Discussant: Robert M. Friedman

A well established gap exists between mental health practices found to be effective through research and what is actually available to children and families. Policies to increase use of evidence-based services are increasingly being adopted to address this gap and increase accountability; however, many agencies and communities lack the infrastructure, support, and general knowledge to work together to identify and implement programs that are effective as well as feasible. Even when these programs are identified and implemented, lack of buy-in by stakeholders, restricted availability, and poor fiscal sustainability often hinder potential for broad-based impact. This symposium will present two Washington State projects that aim to address these barriers through training, infrastructure development and community mobilization. The first, Partnerships for Success, provides a data-driven organizing framework to assist communities to conduct strategic planning and ensure sustainability around children's mental health programming. The second, Project Focus, provides training and consultation to child welfare case workers to identify the mental health needs of children on their case load, and then actively partner with local clinicians who have been trained in evidence-based practices to address mental health needs of foster youth. Though distinct, both projects are part of an overall change agenda, representing public-academic partnerships to build more responsive, effective, and sustainable systems of care. In addition to descriptions of the projects, the symposium will present results and lessons learned from both projects' extensive evaluation components.

Partnerships for Success in Washington State: An Example of a Community-Based Model to Effectively Implement Evidence-Based Practices for Youth

Presenting: Suzanne E. Kerns, Eric J. Bruns, Eric W. Trupin & Gary Enns

The Partnerships for Success model is an organizing framework designed to assist communities conduct strategic planning and ensure sustainability around children's emotional and behavioral health programming. This pilot study in two Washington State counties, evaluated the impact of the model across multiple levels, including county, community, agency and individual-family levels. Evaluation strategies included key informant interviews, stakeholder surveys and pre-post outcome measures. Results provide preliminary evidence of a positive impact across all levels and areas for future model refinement.

Introduction

A well established implementation gap exists between the state of the science regarding effective interventions and what occurs in real-world settings (Hoagwood et al., 2001). Policy-level initiatives, including mandating use of evidence-based services within public mental health agencies, are designed to increase accountability for provision of effective services and address the science-to-service gap. However, many agencies lack the infrastructure, support and general knowledge to identify and implement programs that are feasible and sustainable. A further challenge in community mental health is the ability to reliably conduct interventions with the requisite standards of model adherence and fidelity (Botvin, 2004).

The current study provides a multidimensional evaluation of an organizing framework, Partnerships for Success (Julian, 2006), designed to specifically address effective and sustainable implementation of community-supported evidence-based practices for children's mental health.

This pilot study had three main objectives. The first objective was to determine the relative effectiveness of adapting the Partnerships for Success model to specifically target increasing the availability of evidence based practices within a two-county area. The second objective was to examine community and agency benefits, such as enhanced ability for cross-agency collaboration and coordination of resources. Finally, we examined the specific youth and family-level outcomes resulting from new programming as a result of Partnerships for Success, which for this community was Multisystemic Therapy (Henggeler et al., 1998).

Methods

Participants

Participants in key informant interviews ($N = 8$) included a representative from the Washington State Mental Health Division, two members of the Regional Support Network and five Core Team members (one of which was affiliated with the Regional Support Network). All members of the original Community Collaborative ($N = 39$) and community practitioners ($N = 5$) were asked to complete a stakeholder survey. Responses were received by approximately 33% of the Community Collaborative ($n = 13$) and 100% of the practitioners. Youth outcome data were collected for 39 youth served during the first year of Multisystemic Therapy (MST) implementation. Of the youth, 61% completed treatment. The average age of participating youth was 14.46 (range 11-18). Participating youth were 67% male and 85% Caucasian. Approximately 80% were served with support from Medicaid dollars.

Measures

Key informant interviews. Interviews were semi-structured using a mixed methods strategy. Interviewees were asked to provide responses on a Likert-type scale to fourteen statements and were then asked follow-up questions. Domains assessed included: perceived agency-level benefits, cross-system collaboration, service coordination, ability to respond to the needs of youth in the community, fiscal blending, cost savings, increased access, keeping youth in the community, providing a framework for future mobilization, increasing funding opportunities, and addressing the needs of youth of color. Participants were asked their perceptions of the benefits and challenges of using the Partnerships for Success model as their organizing framework.

Community survey. A 19-question online survey was developed by the University of Washington team, in collaboration with the community Core Team. Categories of questions included: the extent of participation in the community process, satisfaction with various aspects of the community process (incl. timelines and engagement strategies), identification of an appropriate evidence-based practice, success in meeting goals, satisfaction with technical assistance, identification of new partnerships and future goals.

Practitioner Survey. A 24-item survey of MST providers was developed for the purposes of this evaluation. Assessed domains included: administration/organizational supports, program relevance for client base, treatment process, support and assistance and alignment with the community Partnerships for Success process.

Pre-post outcome data. A therapist-record of MST client characteristics at intake and discharge was created. Assessed domains at intake included: demographic information, residential history, school experience, employment, safety and behaviors (including suicidal gestures and attempts, criminal activity and substance abuse), and previous psychosocial and psychopharmacological interventions. Similar domains were assessed at discharge, as well as achievement of treatment goals and/or other successes. Most domains were binary, yes or no responses with a “don’t know” option.

Data analysis

Thematic coding and basic descriptive statistics were utilized to evaluate outcomes related to key informant interviews and practitioner surveys. Pre-post data related to treatment outcomes was analyzed using McNear’s test (a non-parametric test for dichotomous variables).

Results

The evaluation assessed outcomes across multiple indicators and included evaluations at the systems-, agency-, and individual family-levels. Overall, the Partnerships for Success model resulted in positive outcomes across all three levels. Most notably, the project succeeded in providing a solid foundation for cross-agency decision making related to children’s behavioral and emotional health. All participants discussed the economy of scale provided by the process of going through strategic planning. The community succeeded in identifying and implementing Multisystemic Therapy (Henggeler et al., 1998) to address the complex needs of multi-system involved youth. Additionally, several complementary projects and programs were able to be swiftly and effectively implemented as a result of this process, including Triple P-Positive Parenting Program (Sanders, 1999) and Trauma-Focused Cognitive Behavioral Therapy (Cohen, Mannarino & Deblinger, 2006).

Participation in the Partnerships for Success process resulted in enhanced cross-agency relationships and community partnerships, better service coordination and increased access to effective, evidence-based practices. Additionally, participants reported that the model was feasible and could be applied to other teams in the geographic area. Technical assistance from the University provided valuable structure and assisted with buy-in across multiple stakeholders. Finally, the team and stakeholders noted that participation in Partnerships for Success provided long-term strategies for increasing evidence-based practices in the community.

The most notable challenge for this project was an unrealistic timeline. Several challenges could have been mitigated and sustainability planning facilitated if time allowed more thorough problem-solving. Unfortunately, the timeline pressures likely inhibited true transfer of knowledge from the University to the community. Other challenges included maintaining consistent family involvement and managing the perception that the financial benefit of this process is realized primarily with only one community partner.

At the individual family-level, a pre-post treatment assessment of families participating in Multisystemic Therapy revealed many critical indicators, which showed significant reductions in problem behavior. Although not all indicators were significant, all were in the anticipated direction (Table 1). Therapist adherence scores were well above the threshold for MST fidelity (average adherence = 0.75, well above the 0.61 adherence threshold specified by Henggeler, et al., 2002).

Table 1
Pre-Post Differences in Problem Area Domains
for Youth Enrolled in Multisystemic Therapy

<i>Problem area</i>	<i>6-months pretreatment (%)</i>	<i>Post-treatment (%)</i>	<i>p-value</i>
At least one arrest	56	44	.343
Suicide attempt	21	5	.034*
Suicidal gesture	44	31	.059**
Physical violence	69	36	.001*
Property damage	67	41	.003*
Theft	62	38	.041*
Running away	44	33	.133
Worried/anxious	74	67	.607
Alcohol problems	31	23	.223
Drug problems	44	31	.100**

* $p \leq .05$; ** $p \leq .10$

Conclusions

This study provides preliminary evidence supporting the usefulness of an organizing structure, such as Partnerships for Success, to support organizations and communities to effectively plan for and implement evidence-based practices, however results from this process evaluation should be interpreted cautiously due to a generally low response rate and lack of a control group to assist with interpretation of findings at the individual level. However, this multi-level evaluation revealed positive outcomes across multiple domains, for diverse stakeholders, and perhaps most importantly, for the families who were the beneficiaries of the increased access to evidence-based services. The challenges of this process can further inform next steps as well as be addressed in future projects.

Future research can further examine the impact of such a model on cross-system planning and coordination and evaluate the cost-savings of establishing such an infrastructure within a community, enabling timely mobilization around future funding opportunities as well as effective implementation of evidence-based services.

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Project Focus: Effective Mental Health Practices for Washington's Foster Children

Presenting: Shannon Dorsey, Suzanne E. Kerns, Kenyatta Etchison & Eric Trupin

Contributing: Eric J. Bruns

This presentation provides an overview of Project Focus, which aims to better link youth in foster care with appropriate evidence-based mental health practices to improve outcomes. The project involves training and consultation with caseworkers to increase appropriate referrals as well as training and consultation with local clinicians to increase community capacity to provide evidence-based practices. We present the Project Focus research design and initial findings regarding feasibility, acceptability, and effectiveness.

Introduction

Youth living in foster care experience disproportionately high rates of mental health problems compared to other youth. Yet, research shows that many youth in foster care do not receive mental health treatment, or receive treatment that may not be effective.

The goal of Project Focus, funded by the Paul G. Allen Foundation and implemented in partnership with the Washington State Children's Administration, is to improve outcomes for youth in foster care by increasing referral and access to appropriate, evidence-based mental health services tailored to meet specific mental health needs. The project focuses on improving Division of Child and Family Services (DCFS) caseworkers' knowledge of and referral to evidence-based practices (EBP) by providing training and consultation on the following areas:

- Identification of mental health problems using available data and information;
- Evidence-based health and mental health practices; and
- Appropriate EBP referrals in their area for frequently occurring mental health problems of youth in foster care (e.g., disruptive behavior disorders, PTSD and other anxiety disorders, ADHD, depression).

To increase community capacity for providing evidence-based treatments, Project Focus also provides training and consultation for community clinicians who serve youth in foster care. These clinicians receive training in MATCH-ADC (Modular Approach to Therapy for Children focusing on Anxiety, Depression, and Conduct problems; Chorpita & Weisz, 2008).

Methodology

In this presentation, we will describe the implementation of Project FOCUS and the research component of this pilot project, which relies on a community-level matched comparison design with delayed implementation. Specifically, two Children's Administration offices have

received training and project implementation immediately, with the other two offices serving as 'wait list control sites' (delayed implementation). Each condition includes one rural office and one urban office in Washington State. Approximately 60 caseworkers will be enrolled in the study across the two conditions, and approximately 80 youth in foster care (ages 4-14) will be enrolled in the study. Outcomes being examined include knowledge and capabilities among DCFS caseworkers and mental health clinicians, referrals to and provision of EBPs, and outcomes for youth (e.g., improved functioning, placement stability). We utilize standardized self-report measures with clinicians, caseworkers, youth and their foster parents, administrative data on placement outcomes and service use, and key informant interviews with caseworkers and clinicians to gain qualitative data.

Findings

This session presents in-depth qualitative data from an initial feasibility trial of the caseworker training and consultation model, completed in March 2008. In this trial, all caseworkers in the two participating units and their supervisors received 5 hours of training. We tested 2 approaches to consultation. In one unit, we provided consultation to the individual caseworkers. In the second unit, we provided consultation to the unit supervisor, and not to the individual caseworker. Findings indicated that consultation with the individual caseworker was necessary for the training to result in practice change. Caseworkers demonstrated increased caseworker knowledge of EBPs in their community (from a total of 3 EBPs reported at the pre-assessment to a total of 18 reported at the post-assessment). Qualitative thematic analyses of exit interviews with caseworkers who received training and consultation indicated that the consultation aspect was the most helpful component of the model. According to qualitative analyses, consultation related in greater ability to conceptualize which EBPs to which youth with particular mental health problems should be referred and generalization of learning from cases discussed on consultation calls to cases not discussed. Caseworkers who did not receive consultation were somewhat confused about the purpose of the training and retained few of the details and specifics from the training, which had occurred 3 months prior to the exit interview.

Initial quantitative and qualitative findings are now available from caseworker and clinician measures in the current trial (begun in August 2008), as well as selected outcomes at the youth level.

Conclusions

Training and consultation with caseworkers appears to be a viable method of improving caseworker knowledge and ability to connect youth in foster care with evidence-based practices. From the initial feasibility trial findings, consultation appears to be the key ingredient for ensuring that training results in practice change.

Session 23 » 5:00 - 6:00 pm » Salon C

Topical Discussion

From Principles to Practice: System of Care Program Installation and Governance

Panel: Rosalyn Bertram, Janis Bane, Stephen Williams
& Rebecca Johansson

Introduction

This topical discussion will share initial challenges experienced and the eventual strategies taken to overcome them and move forward with the installation of a wraparound program between 2005-2008. Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), a system of care grant was awarded to Harris County, Texas—the third largest county in the United States with over one million children and adolescents. Multiple child and family serving agencies, along with representatives of family based and family advocate organizations, supported the project during the application stage. Upon grant award, numerous stakeholders and agencies (e.g., child protective services, mental health, juvenile justice, education, and others) expected to participate in the implementation and governance of the program, Systems of Hope. These potential partners assumed the system of care grant would function similarly to other multi-agency efforts.

Key Problems in Program Installation

During initial installation and well into the second year of the grant, conflict and miscommunication became common. Incorporating system of care principles, especially family voice, was challenging. Furthermore, during the second-year site review, a facilitated governing board retreat was recommended in order to restructure governance of the grant, and address the following issues:

Size of Governing Board

A history of collaborations by state and local agencies generated strong interest in the grant application. Thirteen separate state and local agencies were identified as original governing board members. According to SAMHSA guidelines, 51% of the governing board would be family members. During year one, the governing board increased in membership to 38 members.

Mistrust of Parent Groups

Although agency executives appreciated the need for family voice in the governance structure, the practice of family voice was new. Likewise, family members on the initial board were passionate advocates who in many instances had previous negative experiences with some agencies on the board.

Organizational Context and Readiness to Adapt Wraparound

While agencies were committed to the grant, real transformation met resistance. Agency leaders sometimes felt that a need for transformation implied their agencies were not producing desired outcomes. Wraparound philosophy and process were not always understood by governing board members and not advocated as the desired practice in those agencies.

Mother Nature and Staff Selection

Harris County was notified of receipt of the grant in close proximity to Hurricane Katrina, which brought a tremendous influx of children and families with mental health needs into its many communities. Necessary efforts to address this crisis interfered with initial staff selection. Following the second-year SAMHSA site visit, the Project Director resigned.

An interim Project Director was identified to follow through with recommended structural changes including limiting the number of board members and increasing diversity in board membership to include family members being served. These significant alterations contributed to conflicted organizational climate and context.

Limitations of Traditional Board and Committee Structure and Process

The number of governing board members and their participation on numerous task forces, committees and subcommittees became a recipe for miscommunication. Committees and subcommittees often replicated efforts and relied upon or blamed personalities as supporters or barriers to change.

Furthermore, increasing representation of family members slowed the decision-making process. Committee and program operations stalled again as family members interpreted family voice as being responsible for approving every decision. Additional complications arose because there were so many different family advocacy groups serving on the governing board.

Choice of Systemic Team Development

At the 2007 Portland Building on Family Strengths Conference, some System of Hope staff and family advocates attended a presentation of a model for multi-system team development that had been successfully applied in Kansas City (Bertram, 2008) and had emerged from early SAMHSA grants (Bertram & Bertram, 2004). Upon governance board review, this model was selected to address SAMHSA recommendations and their unintended effects.

Members of the reduced governing board made preparatory telephone calls that could last as long as 30-60 minutes. In those conversations they invited board members and key staff to consider what Systems of Hope would look like when the grant was complete; they solicited information necessary to achieve the goals of the program and discussed how that information should be shared, how decisions should be made when not everyone agreed, and how conflict should be resolved. In systemic team development, these goals and rules of operation established a context-specific basis for collaboration in assessment and planning. Preparatory calls also prompted participants to identify ecological assets and constraints, and based upon this assessment, summarized current grant implementation strategies.

During a two-day systemic team building process in January 2008, notes from these conversations were de-identified and provided to the governing board and key staff as a reference. Using these preparatory call data, participants were coached to first develop grant agreements on goals and related rules of operation. Working within these parameters, participants used and expanded preparatory call data that assessed ecological assets and constraints related to their newly agreed upon goals, and also to agree upon a summary of their assessment. This summary was then used with their goals to prioritize strengths based activities in a plan of action to reduce constraints and achieve goals. The tone and tenor of participant interaction notably softened and became more collaborative in these final steps of systemic team development. This two-day process jump-started the stalled stages of program installation and initial implementation (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005).

The new governing board with full family participation now operates within the structure of agreements they had created in order to implement and adapt their plan of action.

Who Should Attend

Program installation is not addressed in wraparound literature (Bertram, in review). System of care grant recipients, especially new grantees, will be interested in hearing the experiences from this Harris County site, as well as researchers examining implementation of wraparound and systems of care grants.

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Session 24 » 5:00 - 6:00 pm » Salon D

Topical Discussion

Methodological Considerations in Evaluating Preschool Risk, Resilience, and Trauma: In and Out of Child Welfare

Panel: Adam G. Stein, Erin Stettler, Susan Chinitz & Peter Pecora

Introduction

This paper will provide the foundation for a topical discussion that will examine the real world challenges that are posed in evaluating risk, resilience, and trauma factors in an urban pre-school aged population in a clinical setting. Further emphasis will be directed towards factors that influence evaluation and measurement efforts when children are placed in the child welfare system. Preliminary data from the evaluation efforts at the Albert Einstein College of Medicine, Early Childhood Center will be presented and questions will be posed to the audience in the areas of construct definition, evaluation methods, data collection, and consideration of possible covariates. Discussion will be moderated by a recognized authority in the area of child welfare research. Audience members will be encouraged to make recommendations regarding the nature of these evaluation efforts, which may be incorporated into future evaluation planning.

The Albert Einstein College of Medicine, Early Childhood Center (ECC) is an outpatient child development and mental health services evaluation and treatment facility serving children 0-5 and their families. ECC is located in Bronx, NY a highly urbanized area which epidemiologically has some of the highest rates in the country of numerous risk factors, including poverty, health problems, crime, and violence. Accordingly, many children have been or are currently involved in the child welfare system. Between 20 and 30 percent of our clients are involved in the child welfare system at a given time.

Issues to be Discussed

While there is substantial data and scientific discussion about the influence of risk, resilience, and trauma in child development—there is substantially less clarity when it comes to the best methods for measuring and evaluating these important constructs. This becomes particularly salient within the context of ongoing clinical treatment. Identifying and defining these important variables become more complicated when a child in the child welfare system. We will be focusing on our evaluation efforts of three distinct but related variables: socio-environmental stressors, family supports, and trauma.

In evaluating risk (psycho-social and environmental stressors) we chose the DSM-IV, Axis IV criteria. This decision was made for ecological reasons since the information is being collected as part of standard intake and progress reporting protocol. While these constructs revealed some interesting relationships, most staff questions, interest, and distress was generated in defining and recording these variables. We experienced a

great deal of qualitative inter-staff variability in defining these variables. Staff members had differing opinions about the value of the duration of psychosocial stressors, choice of informant (foster vs., biologic parent), the need to differentiate between acute and cumulative stressors, and the difference between stressors, acute traumatic events, and trauma.

The Family Support Scale (FSS; Dunst, et al, 1996) measures the number of social supports, satisfaction with existing support, and degree of perceived helpfulness. A large literature documents lower risk for depression and for psychological distress more generally for those who enjoy greater social support (Stansfeld & Sproot, 2002). While there is limited psychometric data to support the reliability and validity of the FSS there is great clinical and face validity in identifying supports on which families rely. We have been focusing on the total number of supports. Our efforts have found a mean of 25 supports per family and no significant differences between child welfare involved and non-involved families ($\chi^2 = .867, p = 0.352$). Current efforts are underway to examine reliability and factor structure of a large sample of our population.

Since administration of the Child Behavior Checklist is was an existing part of our intake protocol, we decided to look at the CBCL preschool PTSD scale (Dehon & Scheeringa, 2005) to measure the effects of trauma. Accordingly, over 40% of our population meets suggested cutoff points for symptoms of PTSD. However, this scale has not been validated in a clinical population. Preliminary analysis found a significant difference in PTSD scores of child welfare involved and non-involved children. ($\chi^2 = 4.096, p < .05$). Current efforts are underway to examine clinician impressions of PTSD and reported history of trauma in CBCL-PTSD scale identified individuals, as well as a matched sample of non-identified individuals.

One problem identified by Dehon and Sheeringa as well as others, is the use of DSM-IV criteria in clinical assessment of preschool aged children. They incorporated criteria for the DC:0-3 as well. While utilization of DC:0-3 criteria begins to address the need in this area, its use raises questions about the reliability, validity, and equivalency of the constructs.

Questions for Consideration:

Risk

- In recording and evaluating risk factors what are the advantages of examining acute vs. cumulative circumstances?
- For children residing in child welfare, what are the most reliable ways to collect acute and historical information about strengths and risk factors?

- What are some ecological sound methods of improving clinician inter-rater reliability in recording psychosocial and environmental stressors?
- How might risk factors be reliably differentiated from trauma?

Resilience

- Are family supports a meaningful construct to evaluate resilience and or strengths in our population?
- Can the Family Support Scale be used as a reliable and valid quantitative measure?

Trauma

- In evaluating clinical constructs in preschool aged children such as PTSD what is the value of incorporating additional diagnostic criteria, such as DC: 0-3?
- Is the CBCL-PTSD scale a valid and reliable instrument in identifying PTSD in a clinical preschool population?
- Does placement in foster care itself represent a unique form of trauma?

Who Should Attend

Attendance is encouraged by individuals with interest early childhood, child welfare, and/or program evaluation. Suggested participants include stakeholders with interests in evaluation and outcomes in these areas, clinical service providers and administrators, child welfare personnel and administrators, evaluation professionals, and academic researchers.

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Session 25 » 5:00 - 5:30 pm » Salon G

The Impact of Family Education and Support Services in System of Care Communities

Presenting: Phyllis Gyamfi

Contributing: Yisong Geng, Christine Walrath, Robert Stephens, Nicole White & Susan Drilea

Introduction

Family education and support (FES) services are intended to help families acquire the support they need to cope with the stress and resulting strain that accompany caring for a child with emotional and behavioral disabilities. FES services have been described as “a broad range of interventions intended to educate parents about their child’s disability or train them to manage typical problems, often in combination with social support or group education” (Friesen, Pullmann, Koroloff & Rea, 2005, p. 111). Even though such initiatives have been evolving over the past twenty years, there is very little empirical evidence about the effect of family-led interventions for families of youth with mental health problems. Through both qualitative and quantitative analysis, this study examines the critical elements of FES services, the prevalence of FES, and factors associated with the use of FES services.

Methods

Participants

The study participants were 3,387 children and youth ages 6-18 whose caregivers enrolled in the Comprehensive Community Mental Health Services for Children and their Families Program (Children’s Mental Health Initiative; CMHI). The children and families in this study were served in 52 system of care communities that were initially funded between 2002 and 2006. This paper uses data from the longitudinal outcome study of the national evaluation of the CMHI to assess the demographic, clinical and functional characteristics of children and families receiving family education and support services compared with those who are not receiving these services. In addition, focus groups and interviews were conducted with 21 caregivers, 21 FES service providers and 8 administrative personnel from three system of care communities funded in 2003 and 2004 on the key elements of and consumer satisfaction with FES services.

Measures

Receipt of family support services in the past six months was assessed with the Multi-Sector Services Contacts–Revised (MSSC–R) questionnaire. The MSSC–R was developed specifically for the national evaluation to record parent/caregiver reports of youth and family service use across multiple child-serving sectors. Behavioral and emotional problems were assessed using the Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983), a widely used measure of children’s behavioral and emotional problems in the field of children’s mental health services. Child’s strength was assessed using the Behavioral and Emotional Strength Rating Scale (BERS; Epstein, 2004), a norm-referenced and standardized instrument. The Caregiver Strain Questionnaire (CGSQ; Brannan, Heflinger, & Bickman, 1998) was used to assess the degree of strain experienced by a caregiver resulting from responsibilities related to caring for a child with behavioral problems. The Columbia Impairment Scale (CIS; Bird et al., 1993) was used to assess level of impairment in four basic areas of functioning: interpersonal relations, functioning in job or schoolwork, use of leisure time, and certain broad psychopathological domains. Other data used in the current analysis included demographic information on child age, sex, race, Hispanic ethnicity, custody status, current living situation, referral source, family income, and caregiver education.

Findings

Results from the focus groups and interviews indicated that family organizations provide the mechanism through which family-led education and support services are delivered. In most cases, these services are provided by people identified as parent partners, parent liaisons, parent advocates, parent coaches or peer-to-peer mentors. There are no fees associated with this service and it is offered through both individual and group sessions. Secondary data analysis revealed that 29% of 3,387 children and families received FES services in the first six months of entering systems of care. Analysis on clinical characteristics indicated that children whose caregivers received FES services had more emotional and behavioral problems ($t = -3.57; p < .001$), and lower functioning ($t = -4.49; p < .001$) in the

first six months of services compared to those who did not receive such services. Caregivers receiving FES services reported more strain ($t = -2.56$; $p < .01$). No differences were found with child strengths. Children whose families received FES services were more likely to be in the custody of their biological parents and referred through mental health, education and child welfare than those not receiving these services.

Discussion

The current study provides insight into the characteristics of families and youth in systems of care who receive family education and support services as evidenced by existing service delivery practices in funded communities. The findings suggest that the receipt of FES services is not uncommon, indicating that during the first six months of entry into services, nearly one-third of families received FES services. Receipt of FES services was associated with more emotional and behavioral problems. Since the present results suggest that caregivers who receive support services have youth who enter systems of care with more severe problems than those who do not, it is likely that these services are offered more frequently to families who struggle most. Further analysis will elucidate the factors which lead to FES service receipt. Implications for service planning and the delivery of FES services will be discussed.

Session 25 » 5:30 - 6:00 pm » Salon G

Reducing Stress and Employment Loss for Parents Caring for Children with Mental Health Disorders

Presenting: Eileen Brennan

Contributing: Lisa Stewart, Anna Malsch & Julie Rosenzweig

Introduction

Parents endure work-related stress, and even job loss, as they attempt to accommodate their child's mental health needs through employment adjustments (Rosenzweig, Barnett, Huffstutter & Stewart, 2008). Family members often find themselves in situations in which they are presented with opportunities or requirements to share information about their children's mental health status in the workplace, usually to human resource (HR) professionals. Whether disclosure is planned or arises from an emergency, these exchanges require a parent to divulge information about their child's mental health status in order for them to obtain flexible work arrangements. Often parents are reluctant to share information about their children because they fear stigmatization, or their concerns are minimized and their requests for support are denied (Rosenzweig et al., 2008). Our presentation provides a research-based model for family members and mental health providers to use to provide more effective workplace support and to promote better employment outcomes for parents of children with mental health disorders.

Researchers have documented caregiver stress and employment loss of family members whose children are involved in systems of care (Brennan & Brannan, 2005), and the lack of training that HR professionals have about the needs of these families (Goshe, Huffstutter, & Rosenzweig, 2006). Supervisors and HR managers who have minimal knowledge about the causes of mental health disorders may view requests for flexibility as a reflection of ineffective parenting and indicative of poor professional competence. However, the parents' disclosure is the means by which employers become aware of the unique supports needed by these families.

In order to develop an effective training intervention with HR professionals, our research team conducted focus groups of parents and HR professionals to explore the following questions: (a) How can family members obtain the support within the workplace that they need to lower stress and to integrate work and family responsibilities? and (b) What do

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HR professionals need to know to facilitate work-life integration for these employees? Our presentation reports a tentative model of communication competency developed using a grounded theory approach, and suggests that both parents and employers must use relational and collaborative communication skills (Rosenzweig, Armstrong, Davis, & Malsch, 2008).

Methodology

Five focus groups of employed parents of children with mental health disorders ($N = 28$) and three focus groups of HR professionals ($N = 17$) were conducted in the Pacific Northwest. The family members were recruited through local parents' groups and through a national conference. They were generally middle-aged ($M = 41.5$; $SD = 9.1$) females with 57% reporting a high school diploma as their highest level of education. They were employed between 7 and 60 hours per week, 68% had benefits, and the median family income was between \$30,000 and \$39,000 per year. The HR professionals belonged to a local chapter of a national HR organization and were generally female (87%) and middle aged ($M = 45.2$; $SD = 8.4$). They were experienced in the HR profession ($M = 15.6$ years, $SD = 9.1$ years) and 58.8% held certifications in the field. Investigators worked independently with the transcripts to generate preliminary codes using both latent and manifest content analysis techniques. First level codes were compared in joint meetings. Second-level coding focused on establishing substantive themes and relationships among primary-level codes.

Results

Communication competence in the workplace was found to have key dimensions that differed for family members and for HR professionals, but which required relational and collaborative skills on the part of each group. Central to the concept of communication competency for family members is the need for mental health literacy and speaking up as vehicles for parental voice and empowerment. Parents who engage in the process of developing mental health literacy have absorbed information, made sense of it, and formed beliefs about mental health for their children

and themselves. Mental health literacy leads to interactional behaviors including discussing their children's condition and needs with employers, and leading HR professionals to some knowledge of children's mental health and the requirements to participate in systems of care. Employees must also make the decision to speak up for what they and their family members need while balancing this disclosure against possible reprisals and stigmatization. On the other hand, HR professionals need to engage in conversations that invite disclosure by employees of their family's needs, while respecting the confidentiality and privacy of the employee.

Conclusion

Caring for a child with a mental health disorder while maintaining employment is challenging and can lead to parental stress and job loss, both of which have implications for the entire family's well being. Communication is a powerful tool for both caregivers and the HR professionals with whom they interact. Based on our above research findings regarding the components of competent communication, we conclude by describing a training intervention for HR professionals designed to increase the knowledge and skills that will enable them to have constructive and successful dialog with employees who are caring for children with mental health disorders.

Session 26 » 5:00 - 6:00 pm » Salon H

Topical Discussion

Critical Success Factors to Achieve Family-Driven, Youth-Guided System Planning

Panel: Myra Alfreds; Carol Hardesty, Candy Kennedy & John Ferrone

Overview

The Westchester Community Network, Westchester County, New York is a graduated SAMHSA system of care community that has served as a learning resource for system of care communities since 2000. Westchester was a Host Learning Community while a federal grant site and continues to be a Team Learning Center for currently funded communities. The team operates under a Theory of Change in which all issues and challenges emerge directly from the families and youth. Our process is highly replicable as is our structure and community organization foundation. Our process includes leadership development for parents and youth, training parents and youth as spokespersons, and developing community based leadership councils in each of our resource centers which drive programming and reflect the authentic views of parents and youth. This approach (supported with data and outcome studies) has proven to be a highly effective way to develop a system of care, as well as a successful means to market the core system of care philosophy to ultimately ensure sustainability. Myra Alfreds, Westchester County, New York Director of Children's Mental Health Services will be joined by Carol Hardesty, Executive Director of Family Ties, Westchester's family support organization to represent their successful history and critical success factors towards building an effective system of care. The development of a free standing, independent family and youth movement has been a giant step in the construction of a well functioning system of care. Commitment to the notion that we are all involved in a social justice movement for the success of youngsters who would not otherwise succeed is at the heart of our family driven system-of-care. That commitment to the family movement began more than 15 years ago, with government making a conscious decision to share power with families, and with the family movement making a similar decision to trust government. The family organization has greatly expanded over time, has a very solid fiscal base with diversified funding from a wide variety of public and private funding sources, and is integral to all aspects of

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the system: policy development, program planning, direct service, training and evaluation. Seven family resource centers throughout Westchester serve as a "hub" for the system-of-care, providing a setting for families to meet, and where child and family team meetings, trainings, community organization meetings and other functions of the Westchester Community Network take place.

Youth Forum, Westchester's youth organization, emerged from the family organization, and currently has its own budget and staff, mentored by a local mental health and community service organization. The family and youth movement components have numerous shared activities and often develop joint advocacy and policy positions. Youth Forum members participate in system level and community meetings and have a powerful planning committee attached to our central planning committee.

- Westchester's system of care foundation rests on:
- Shared Vision & Principles – An 18-Year History of Working Across Systems
- Leadership
- Model Implementation of a System-of-Care
- Families/Youth As the Driving Force in the Change Process
- Effective Structure for Wraparound Coordination
- Non-Traditional Clinical Practices/Wraparound Designs Used in Westchester:
- Ongoing Expansion of the Infrastructure
- Social Marketing Efforts

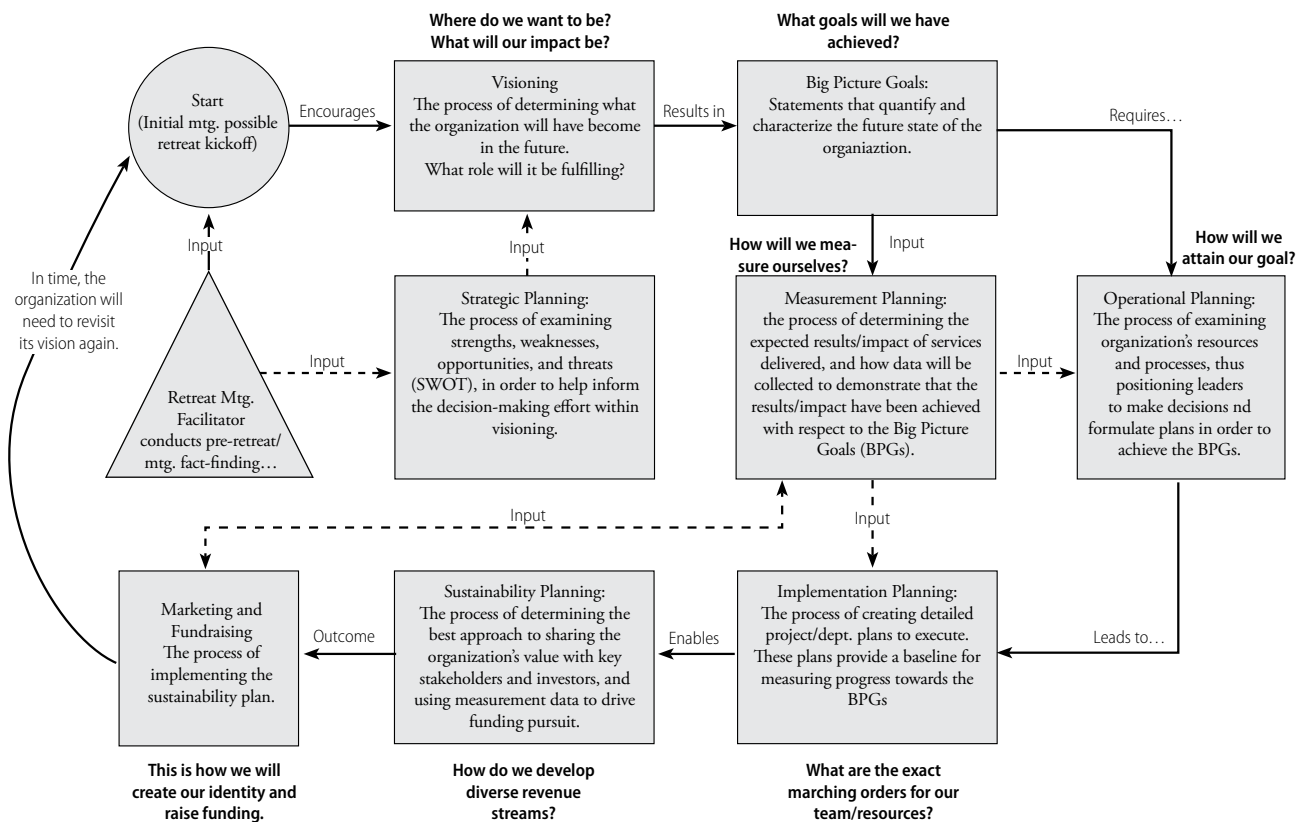
The Nebraska Federation of Families for Children's Mental Health has been the primary driver of change with respect to the strengthening of family organizations across Nebraska. Family organizations in Nebraska have been striving to reach a higher level of service delivery and have found that basic elements of business and organizational effectiveness need to be strengthened in order to remain competitive and fund-worthy in the realm of family service. Nebraska leaders recognized the need for

strong family organizations as an essential component to the system of care and used SAMHSA grant funding to provide technical assistance that ranges from individual one on one coaching of the Executive Directors of organizations, to multi-stakeholder visioning and planning with the organizations. Ultimately, the technical assistance has focused on helping family organizations to evolve and enhance their organizational business acumen, based on the premise that a sound business organization is better able to sustain itself and participate in the system of care. The outcome has been a movement of the family organizations along a path from passionate grass roots gatherings to contract-signing, program-delivering, and future-shaping non-profit organizations that operate as successful businesses. Candy Kennedy, Executive Director of the Nebraska Federation of Families for Children's Mental Health and John Ferrone, a national business consultant, will represent Nebraska.

The following Model, The Elements of Organizational Effectiveness, will be used to guide discussion about the core capacities of a family organization that need to be strengthened in order for a family organization to operate as a business and thereby become an effective partner within the system of care (a larger copy will be provided during the event).

The Topical Discussion will weave together the insights from both NY and NE, and invite participants to ask questions and to chime in with their own best practices. Ultimately, participants will be challenged and stimulated to assess their current or future system of care initiative and core family organization(s) with respect to the best practices shared during this Topical Discussion. Participants will leave with a plethora of handouts and tools to facilitate future discussions as they return to their respective systems.

Figure 1
Elements of Organizational Effectiveness Model



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Monday – 5:00

Session 27 » 5:00 - 6:00 pm » Salon I

The National Behavior Research and Coordination Center: Overview and Final Findings

Presenting: W. Carl Sumi, Michelle Woodbridge & Mary Wagner

Introduction

Although research conducted in the last several years suggests some potentially promising approaches to behavior interventions, much of it lacks the rigorous, experimental base that is the “ideal method” (National Research Council 2002, p. 109) for determining the true efficacy and effectiveness of interventions. A commitment to increasing the scientific rigor of education research and, thus, its potential for improving practice and student outcomes has been codified in the Education Sciences Reform Act of 2002. This law has sparked the reorganization of federally sponsored education research and the formation of the Institute of Education Sciences (IES) and its *What Works Clearinghouse*—an entity charged with screening education research to identify studies that meet standards of scientific rigor, including an experimental design, and, therefore, whose results can be trusted to identify “what works” in improving student outcomes.

In 2004, the Office of Special Education Programs (OSEP) funded four Behavior Research Centers (BRCs) and the National Behavior Research Coordination Center (NBRCC) to investigate the effectiveness of interventions for children with serious behavior problems. Since then, the funding has transferred to the National Center for Special Education Research in the Institute of Education Sciences (IES). The BRCs, in collaboration with NBRCC, conducted randomized controlled trials of behavioral interventions that were found to be efficacious in previous research. The four BRCs were located at the University of South Florida (in collaboration with the University of Colorado at Denver), Vanderbilt University (in collaboration with the University of Minnesota and Virginia Commonwealth University), the University of Washington, and at the Oregon Research Institute. The purpose of this presentation is to describe how the NBRCC is coordinating, synthesizing, and conducting analyses across the BRCs and present findings from the four years of the project which includes complete baseline and posttest data for core participants including one year follow up data when available. The following are descriptions of the four BRCs and the NBRCC:

University of Washington BRC

The University of Washington BRC evaluated the Check, Connect, and Expect (CC&E) program. CC&E is based on the theory that relationships with school staff, reinforcement of clear expectations and social behavior, and engagement in school activities contribute to improved academic and social outcomes of students. Therefore, the intervention focuses on improving students’ positive relationships and prosocial behavior via increased school staff reinforcement and feedback.

University of South Florida BRC

The University of South Florida BRC team evaluated the Prevent-Teach-Reinforce (PTR) intervention. PTR is modeled after a positive behavior supports approach and is a team process through which an individualized intervention is developed and implemented. PTR is based on the theory that well-conducted functional behavioral assessments and sound positive behavior support plans for children with severe behavior problems will: (a) decrease the occurrence of maladaptive target behaviors, (b) increase the occurrence of appropriate prosocial behaviors, and (c) consequently produce positive outcomes in the areas of behavior, academics, and lifestyle changes for the child and family.

Oregon Research Institute BRC

The Oregon Research Institute BRC evaluated the First Step to Success intervention, a 3-month process that incorporates three components in an effort to improve the behavior and academic performance of students with severe behavior problems. Components include: universal screening using the Systematic Screening for Behavior Disorders (SSBD), a school component, and a family-based intervention.

Vanderbilt BRC

The Vanderbilt BRC’s secondary-level, classroom-based intervention was directed toward students receiving special education services in self-contained classrooms and toward students in general education classrooms who are at risk for developing behavior problems. Components include: (1) academic tutoring in reading; (2) teacher self-monitoring of classroom management; (3) the Good Behavior Game for improving students’ classroom behavior; and (4) behavior consultants in classrooms 3-5 hours per week. These interventions are based on the theory that student behavior is directly affected by classroom environment and practices. Training and motivating teachers to engage in practices known to improve the classroom environment will result in improved student behavior and learning.

National Behavior Research and Coordination Center

The NBRCC was funded to work closely and effectively with the four BRCs to:

- Develop and implement a *data coordination plan*—determine uniform measures of context, implementation, participation, outcomes, and satisfaction appropriate to the interventions being tested.
- Develop and implement a *data synthesis plan*—develop and support BRC staff in the use of a Web-based data system that will collect core data from each site which will be used in the cross site analyses.
- Develop and implement a *data analysis plan*—determine research questions regarding the context, implementation, participation, outcomes, and satisfaction of each intervention; how these factors compare across interventions; and how these factors vary for students, settings, and schools with different characteristics.
- Develop and implement a *dissemination plan*—develop a multifaceted dissemination plan to bridge the research-to-practice gap by reaching diverse practitioner, policy, consumer, advocacy, and research communities.

Data Collection

A comprehensive battery of data collection instruments were used to assess the efficacy of the interventions tested by the BRCs. Each BRC collected their data and transmitted the data sets to the NBRCC via a secure internet site. Data collection instruments were separated into four categories:

- Student level—basic demographics, school records, office discipline referrals, the Social Skills Rating System (Teacher version), Woodcock Johnson-III Letter Word subtest, oral reading fluency, and observations of academic engaged time.
- Classroom level—classroom/teacher survey and the Classroom Atmosphere Rating Scale.
- School level—school characteristics survey and the School-wide Evaluation Tool.
- Implementation level—social validity and alliance measures.

Conclusion

The National Center for Special Education Research in the Institute of Education Sciences funded four Behavior Research Centers (BRCs) and the National Behavior Research Coordination Center (NBRCC) to investigate the efficacy of school-based interventions for children with serious behavior problems (originally funded by OSEP). The BRCs, in collaboration with NBRCC, conducted randomized clinical trials of school-based behavioral interventions that were found to be efficacious in previous research. The NBRCC coordinated and synthesized the cross-site

data collection and conducted analyses across the BRCs. The final task of the NBRCC is to disseminate the information learned from the cross-site work accomplished by the BRCs. Dissemination activities are taking place in this final year of the NBRCC contract.

References

- National Research Council. (2002). *Scientific research in education*. R. J. Shavelson & L. Towne (Eds.). Washington, DC: National Academy Press.

Session 28 » 5:00 - 6:00 pm » Salon J symposium

2008 Honoring Excellence in Evaluation (HEE) Event: Recipients Share their Work

Chair: Sylvia K. Fisher

Discussant: Laura Whalen

Purpose of the Honoring Excellence in Evaluation (HEE) Initiative

Evaluation is an integral element of the Comprehensive Community Mental Health Services for Children and Their Families Program and is essential to the success of funded system of care grantee communities at both the national and local levels. Many resources and extensive efforts are dedicated to important local and national evaluation activities within funded system of care grantee communities. Accordingly, the Honoring Excellence in Evaluation (HEE) initiative acknowledges the superior efforts of system of care grantee communities to conduct evaluation activities to improve site-based decision-making, improve service delivery, and achieve long-term sustainability. The HEE initiative has three major objectives:

- Recognize evaluation team accomplishments
- Emphasize important evaluation domains
- Disseminate examples of local and national evaluation best practices at a national level

Inaugural 2008 HEE Event. The inaugural 2008 HEE event celebrated outstanding achievements by funded communities at both the national and local evaluation levels. This important event was launched at the July 2008 Training Institutes sponsored by Georgetown University, and will henceforth be conducted regularly to showcase the talents, strengths, and achievements of the system of care communities that are recognized. This symposium will feature presentations of the work that was recognized by the HEE event and include discussion of the superior evaluation process, project, and products produced by honorees.

Program and Procedures

HEE Submission Categories. Three categories were recognized by the HEE: Evaluation Operations; Involving Youth and Family Members in Evaluation; and Evaluation Data Use and Dissemination. Category descriptions and criteria for judging submissions were developed with the assistance of an advisory group made up of local program and evaluation representatives, national evaluation team members, and input from CAFB.

Submissions Summary. Twenty-four (24) of the 57 federally funded system of care communities that were initially funded between 2002 and 2006 submitted at least one submission. This resulted in a total of 36 submissions that were reviewed by the panel, amounting to 42% of these sites: Evaluation Operations ($N = 11$); Involving Youth and Family Members in Evaluation ($N = 9$); and Evaluation Data Use and Dissemination ($N = 16$).

Review Panel. A panel of 9 reviewers was identified and included representatives from a variety of program and evaluation technical assistance providers including members of the national evaluation team, Technical Assistance Partnership, University of South Florida, Federation of Families, representatives from currently funded system of care communities, and a representative from the Child, Adolescent and Family Branch.

Recipients of the 2008 HEE Recognition. Each community that was rated within the top 3 scoring rankings receives a commemorative item and a certificate to acknowledge their excellence in the category for which they were selected. Communities tied in the top 3 scoring rankings were all recognized. A total of 6 communities were selected for recognition for the 3 HEE categories, as shown in Table 1.

These recipients will have the opportunity to share and discuss their recognized work with symposium participants. This discussion represents an excellent opportunity to network with colleagues about enhancing the level of all local and national evaluation activities throughout systems of care.

Future Goals for the HEE Initiative

This symposium at the 2009 USF Research and Training Conference represents an important venue to highlight the evaluation work of recipients of the 2008 HEE recognition. USF RTC attendees offer an appropriate and appreciative audience of researchers and evaluators to share and discuss successful and cutting edge evaluation approaches, activities, and products from communities recognized at the event in July 2008. The HEE initiative also has value from a CQI perspective, through the review of submissions and by encouraging local evaluation teams to strive for excellence in their evaluation efforts. It is anticipated that recognition of accomplished and meritorious evaluation products will encourage a high level of achievement in evaluation teams throughout all system of care communities.

Table 1
Recipients of 2008 Recognition by Category

Category Name	Level	Community Name
Evaluation Data Use and Dissemination	Gold	Family Voices Network of Erie County
Evaluation Data Use and Dissemination	Silver	Columbia River Wraparound
Involving Youth and Family Members in Evaluation	Gold	CEDDERS I Famagu'on-ta Evaluation Project
Involving Youth and Family Members in Evaluation	Silver	Community Solutions
Involving Youth and Family Members in Evaluation	Silver	Family Voices Network of Erie County
Evaluation Operations	Gold	Community Solutions
Evaluation Operations	Silver	Rhode Island Positive Educational Partnership
Evaluation Operati	Silver	STARS for Children's Mental Health

Tuesday, March 3 Events

7:30 am	Registration & Networking Breakfast
8:30 am	Gwen Iding Brogden Distinguished Lecture Series: J. David Hawkins
10:45 – 11:45 am	Concurrent Sessions 29–35
11:45 am	Lunch on your own
1:30 – 3:00 pm	Concurrent Sessions 36–42
3:15 – 4:15 pm	Concurrent Sessions 43–49
4:15 – 5:15 pm	Concurrent Sessions 50–56
5:30 – 7:00 pm	Poster Presentations & Networking

Tuesday Plenary

8:30 AM Salons E & F

Gwen Iding Brogden Distinguished Lecture Series

Planning for Prevention

J. David Hawkins, PhD, Endowed Professor of Prevention and Founding Director of the Social Development Research Group, School of Social Work, University of Washington, Seattle.

During his prestigious career, Dr. Hawkins has sought to identify risk and protective factors for health and behavior problems across multiple domains and to understand how these factors interact. He develops and tests prevention strategies, which seek to reduce risk through the enhancement of strengths and protective factors in families, schools, and communities. During this lecture, Dr. Hawkins will share his impressions on how the methods of prevention can best be embedded in public health-oriented systems of care.

J. David Hawkins, Ph.D. is principal investigator of the Seattle Social Development Project, a longitudinal study of 808 Seattle elementary school students who are now 33 years old. This project began in 1981 to test strategies for promoting successful development. He is also principal investigator of the Community Youth Development Study, a randomized field experiment involving 24 communities across seven states testing the effectiveness of the Communities That Care prevention system developed by Hawkins and Richard F. Catalano. He has authored numerous articles and several books as well as prevention programs for parents and families, including Guiding Good Choices, Parents Who Care, and Supporting School Success. His prevention work is guided by the social development model, his theory of human behavior.

He is a past President of the Society for Prevention Research, has served as a member of the National Institute on Drug Abuse's Epidemiology, Prevention and Services Research Review Committee, the Office for Substance Abuse Prevention's National Advisory Committee, the National Institutes of Health's Study Section for Community Prevention and Control, the Department of Education's Safe, Disciplined, Drug-Free Schools Expert Panel, and the Washington State Governor's Substance Abuse Prevention Committee. He is a member of the Editorial Board of Prevention Science. He is listed in Who's Who in Science and Engineering, was awarded the 1999 Prevention Science Award from the Society for Prevention Research, 1999 August Vollmer Award from the American Society of Criminology, and the 2003 Paul Tappan Award from the Western Society of Criminology. He is a Fellow of the American Society of Criminology and the Academy of Experimental Criminology. He is committed to translating research into effective practice and policy to improve adolescent health and development.

Tuesday Special Sessions

10:45–11:45 AM, Meeting Room 8-10

Conversation Hour with J. David Hawkins

Join Dr. Hawkins for an informal question and answer session where participants can address the application of prevention methodologies in policy, planning and practice.

1:30–3:00 PM, Meeting Room 8-10

Topical Discussion Rapid Ethnography as Community-Based Participatory Research: Real Research for Real World Settings

Panel: Sharon Hodges and Kathleen Ferreira, Department of Child & Family Studies, Louis de la Parte Florida Mental Health Institute, University of South Florida, Myra Alfreds, Children's Mental Health Services, Westchester County, and Knute Rotto, Choices, Inc.

Community-based participatory research is described as a collaboration between researchers and participants, in which community stakeholders are engaged as members of the research team. The utilization of this type of research model within the field of mental health has broadened over the last few years, particularly in relation to community change efforts. Rapid ethnographic methods are often used by a research team to collect a large amount of data within a short period of time. This topical discussion will describe the integration of community-based participatory research and rapid ethnographic methods in the study of system-of-care communities. Leaders from two communities that participated in Case Studies of System Implementation will describe their experiences during the research project, including the challenges and benefits of this type of research and how they have utilized study results. The topical discussion will allow audience members to engage in discussion around this process.

3:15–2:30 PM, Meeting Room 8-10

Special Issue Discussion Best Practices for Mental Health in Child Welfare

Panel: Lisa Romanelli, The REACH Institute, New York, NY, Peter Pecora, Casey Family Programs, Seattle, WA, Robert Hartman, DePelchin Children's Center, Houston, TX, Corvette Smith, Harlem Dowling – West Side Center, New York, NY

The 2007 Best Practices for Mental Health in Child Welfare Consensus Conference brought together experts in the fields of child welfare and mental health research, policy and services as well as parent and youth child welfare advocates to discuss the best ways to address the mental health needs of youth in the child welfare system. As a result of the conference, 32 guidelines covering the areas of mental health screening and assessment, psychosocial interventions, psychopharmacological interventions, parent support, and youth empowerment were developed. This discussion will provide a brief overview of the guidelines, their development, and rationale and discuss the implications of the guidelines from the perspective of child welfare agencies and families.

Tuesday, March 3 » 10:45 am

Session 29 Salon A-B	Substance Use, and Youth and Family Characteristics: Effects on Service Recommendations and Delivery <i>Melissa Whitson & Joy Kaufman</i>	Page 127
	Differences in Patterns of Substance Use in Caucasian and African-American Adolescents <i>Amy Daniels</i>	Page 128
Session 30 Salon C	Symposium—Systems of Care Practice Review's Impact Home and Abroad (Iowa and Ottawa) <i>Chair: Mary Armstrong</i> <i>Discussant: Myra Alfreds</i> Iowa's Children's Mental Health System Evaluation utilizing the SOCPR <i>Stephen R. Roggenbaum, Victoria L. Hummer & Pamela R. Alger</i> Using the SOCPR to Facilitate System Transformation Efforts in Ottawa, Canada <i>Natasha Tatartcheff-Quesnel, Francine Gravelle & Michael Hone</i>	Page 129
Session 31 Salon D	Communication and Interaction of Pediatricians with Systems of Care <i>Kara S. Riehlman</i>	Page 131
	Improvement for Youth with Disruptive Behaviors Provided Evidence Based Practices <i>Charles Mueller, Ryan Tolman, Chad Ebesutani & Adam Bernstein</i>	Page 132
Session 32 Salon G	Trends, Challenges & Opportunities in Conducting Culturally-Sensitive Evaluations of Child Mental Health Programs <i>Alisha Nichols Johnson, Monica Mitchell & Jessica Valenzuela</i>	Page 133
	Financing and Sustainability in American Indian and Alaska Native (Tribal) Systems of Care <i>Holly Echo-Hawk, Anna Krivelyova & Carolyn Lichtenstein</i>	Page 134
Session 33 Salon H	System-of-Care and Usual Services in the U.S.: Comparing Service Outcomes <i>Kathleen Pottick & Ramona Perry</i>	Page 135
	Multilevel Framework for Integrating the Formative and Summative Functions of Evaluation in Mental Health <i>Ana Maria Brannan</i>	Page 137
Session 34 Salon I	Social Connectedness or Families in Wraparound: Implications for Practice <i>James Cook & Ryan Kilmer</i>	Page 140
	Selecting Residential or Community Based Care: Parent Survey Results <i>Amy Starin</i>	Page 141
Session 35 Salon J	Symposium—The Statewide Implementation of Evidence-Based Practice: Outcomes and Lessons Learned from the Evaluation of MST in Connecticut <i>Chair: Jennifer Schroeder</i> Is MST Effective for Connecticut's Highest Risk Children and Youth? Quantitative Outcomes from a Statewide Evaluation of MST <i>Jennifer Schroeder & Christian Connell</i> How is MST Working in Connecticut? Qualitative Outcomes from a Statewide Evaluation of MST <i>Jennifer Schroeder</i> What are the Lessons Learned from the Statewide Dissemination of an Evidence-Based Practice? MST, Knowledge Transfer, and Policy in Connecticut <i>Robert P. Franks</i>	Page 143

Special Meeting » 10:45 - 11:45 am » Room 8-10

Conversation Hour with J. David Hawkins

Join Dr. Hawkins for an informal question and answer session where participants can address the application of prevention methodologies in policy, planning and practice.

Session 29 » 10:45 - 11:15 am » Salon A-B

Substance Use, and Youth and Family Characteristics: Effects on Service Recommendations and Delivery

Presenting: Melissa Whitson & Joy Kaufman

Introduction

Systems of care were developed in response to the need for more appropriate and accessible preventive and treatment services for children with severe emotional and behavioral difficulties and their families. Histories of substance use by youth and their families have been identified as risk factors for increased substance abuse, mental health symptoms, and negative outcomes in systems of care (Hawkins, Catalano, & Miller, 1992; Nation et al., 2003). In addition, because system-of-care services are adaptive to diverse community settings, individual and family characteristics also have a significant impact on services (Walrath, Ybarra, & Holden, 2006). However, there has been a lack of research focused on service recommendations and delivery, as well as how pertinent pre-referral risk factors and characteristics proximally impact these system-level indicators (Tebes et al., 2005; Walrath et al., 2006). The number and nature (e.g., mental health, juvenile justice) of service referrals and whether or not those recommended services were received by families are critical features of a system of care. The purpose of the current study was to assess how substance use risk factors and youth and family characteristics were related to the amount of mental health, juvenile justice, and total services recommended for and received by these youth in a school-based system of care.

Methodology

The Partnerships for Kids (PARK) project is a school-based system of care in Bridgeport, CT, and is funded by the SAMHSA's Center for Mental Health Services as part of the Comprehensive Community Services for Children and their Families Program. At intake, families were invited to participate in a comprehensive outcome evaluation. The present study includes baseline data from a series of questionnaires regarding demographic variables (completed by parent/caregiver) and substance use (completed by parent/caregiver and youth).

Participants were 168 youth, between the ages of 11 and 19, and their parent/caregiver. The sample was overwhelming male (61.3% boys; 38.7% girls). 38% of youth identified as Hispanic or Latino, 19.3% identified as Black or African American, 0.7% as White, and 0.7% as American Indian or Alaskan Native (Missing = 40.7%). Of participants who reported an annual income, 80% reported an income of less than \$25,000.

Two separate multivariate multiple regressions were employed through the AMOS 17.0 statistical package. Both regression analyses examined gender, income, race, youth substance use, and family substance use as the predictor variables. A crosstabs analysis revealed an interaction between gender and youth substance use, so an interaction term was created for this variable and included in the analyses as another predictor variable. For one of the analyses, the criterion variables were number of juvenile justice services recommended at intake, number of mental health services recommended, and number of total services recommended. For the second analysis, the criterion variables were number of services received in all three domains. In order to address missing data, AMOS computes analyses using Full Information Maximum Likelihood (FIML).

Findings

Results of multivariate multiple regressions revealed that youth and their families who reported lower incomes were recommended more services ($\beta = -.19, p < .05$), but income was not associated with the number of services received. Youth who identified themselves as Black or Hispanic were not recommended more services than youth who identified as White or Other, but they did receive more mental health ($\beta = .17, p < .05$) and total services ($\beta = .21, p < .01$). This represents a positive development in response to reported racial disparities in service provisions. Finally, the interaction variable was statistically significant. Specifically, girls who reported using drugs or alcohol were recommended and received more services than boys who reported using drugs or alcohol (juvenile justice recommended, $\beta = .32, p < .001$; mental health recommended, $\beta = .58, p < .001$; total recommended, $\beta = .54, p < .001$; juvenile justice received, $\beta = .34, p < .001$; mental health received, $\beta = .50, p < .001$; total received, $\beta = .48, p < .001$). Reporting that a family member has a drug or alcohol problem was not significantly related to services either recommended or received.

As of the date of this proposal, the PARK project has completed its sixth and final year and the complete data set is currently being compiled. By the time of the conference, a larger sample size should be available to include longitudinal outcome data into a path analysis that displays the positive impact that the number of services received have on child behavioral outcomes.

Conclusions

For this sample of youth in a school-based system of care, it appears that girls' drug use was identified as more in need of services than boys' drug use, and family drug use did not impact service recommendations. These results highlight the need to evaluate the referral process within systems of care and factors that influence treatment planning decisions in order to ensure that at-risk youth are identified and equitably recommended appropriate preventative services.

References

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- Walrath, C. M., Ybarra, M. L., & Holden, E. (2006). Understanding the Pre-Referral Factors Associated With Differential 6-Month Outcomes Among Children Receiving System-of-Care Services. *Psychological Services, 3*(1), 35-50.

Session 29 » 11:15 - 11:45 am » Salon A-B

Differences in Patterns of Substance Use in Caucasian and African-American Adolescents

Presenting: Amy Daniels

Introduction

Racial differences in the prevalence of adolescent substance use have been frequently reported.¹⁻³ Caucasian youth have higher lifetime rates of overall substance use,² and are more likely to have lifetime alcohol, cigarette and illicit substance use than African-American youth.³ Past studies have also demonstrated that utilization of substance use services differ according to race, with African-American youth accessing substance use services less often than their Caucasian peers.⁴ Despite this knowledge, further research is needed to better understand patterns of substance use in Caucasian and African-American adolescents entering services. Identifying groups of adolescents with similar characteristics of substance use will enable systems of care programs to provide individualized services to these youth and their families and to identify adolescents who may need more intensive services upon entry into the program. This study extends previous research on racial differences in substance use among adolescents and examines patterns of substance use among Caucasian and African-American adolescents entering systems of care.

Method

Sample

Baseline data for children and families participating in the national evaluation of the Children's Mental Health Initiative from 45 grantee sites that received their initial funding between 1997 and 2000 were used in the current study. The sample ($n = 4615$) included Caucasian and African-American adolescents, ages 11 to 21 years. Mean age was 13.9 years. Sixty-four percent of the sample was male ($n = 1506$) and 68% were Caucasian. Household income levels ranged from 25% earning less than \$10,000 to 5% earning over \$75,000. Adolescents were referred into the system of care from mental health agencies (31%), juvenile justice (18%), school systems (18%), child welfare (14%), caregivers and youth (7%), and other sources (12%).

Measures

Youth report of lifetime substance use was obtained at intake into services. Adolescents were asked to report whether they had ever used substances (out of a total of 14 substances or substance groups). This information was used to create the following five lifetime substance use variables: alcohol, cigarettes, marijuana, other illicit/prescription drugs (inhalants, psychedelics, heroin, crack/cocaine, amphetamines, Quaaludes, barbiturates, tranquilizers, and narcotics), and over the counter/non-prescription drugs.

Information on race, age, sex, household income, caregiver education level, custody of child, Medicaid status, and referral source were obtained from caregiver report. Information on race/ethnicity was used to create a mutually exclusive race variable (non-Hispanic Caucasian/non-Hispanic African-American).

Analyses

Descriptive statistics were generated and tests for differences in proportions of lifetime substance use between Caucasian and African-American youth were performed.

Patterns of substance use will be examined using Latent Class Analysis (LCA). LCA is a statistical technique that groups individuals into mutually exclusive classes on the basis of their characteristics. Children in one class share similar characteristics with each other and differ from children in the other classes. Several class models will be estimated and the model that best fits the data will be selected based upon multiple

sources of information,⁵ including Akaike Information Criterion (AIC), Bayesian Information Criterion (BIC), the sample-size adjusted BIC, and entropy (classification accuracy). The models will be run separately for Caucasian and African-American youth and the prevalence of class memberships will be compared.

Preliminary and Anticipated Findings

Prevalence rates of substance use are reported in Table 1. Caucasian adolescents were significantly more likely to report lifetime use of alcohol, cigarettes, other illicit/prescription drugs and over the counter/non-prescription drugs than African-American adolescents.

The latent class analyses are currently underway. It is anticipated that multiple class models will be identified for both Caucasian and African-American adolescents. While the specific class models are unknown, it is anticipated that there will be a low use group (youth who endorsed few, if any substances), a moderate use group (youth who were highly likely to endorse alcohol, cigarette and marijuana use and less likely to endorse illicit/prescription and over the counter/non-prescription drug use), and a high use group (youth with a high probability of endorsing all five substance groups). It is expected that the majority of adolescents will fall into a low use group and a small proportion of the adolescents will fall into a high use group. It is also expected that there will be some differences in the proportion of Caucasian and African-American youth endorsing these substances within each of the classes. For example, given the higher prevalence of other illicit/prescription drugs use among Caucasian youth, we may find a pattern of substance use where the proportion of Caucasian youth who endorse those substances is greater than the proportion of African-American youth who endorse the same substances.

Implications

A better understanding of racial differences in patterns of substance use among children entering mental health systems of care will assist clinicians in identifying groups of children who may need more intensive services when they enter into the program. It will also enable providers to contextualize treatment planning and service provision in a culturally relevant way.

Table 1
Lifetime Prevalence of Substance Use

	Caucasian ($n=3164$)	African-American ($n=1451$)	<i>P</i> value
Alcohol	41%	32%	<.001
Cigarettes	48%	34%	<.001
Marijuana	47%	44%	.114
Other illicit/prescription drugs	20%	7%	<.001
Over the counter/non-prescription drugs	9%	4%	<.001

References

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⁴ Heflinger, C. A., Chatman, J., & Saunders, R. C. (2006). Racial and gender differences in utilization of Medicaid substance abuse services among adolescents. *Psychiatric Services*, 57(4), 504-511.

⁵ Nylund, K. L., Asparouhov, T., & Muthen, B. (2007). Deciding on the number of classes in latent class analysis and growth mixture modeling: A Monte Carlo simulation study. *Structural Equation Modeling*, 14(4), 535-569.

Session 30 » 10:45 - 11:45 am » Salon C

symposium

Systems of Care Practice Review's Impact Home and Abroad (Iowa and Ottawa)

Chair: Mary Armstrong

Discussant: Myra Alfreds

Two studies selected the System of Care Practice Review (SOCPR) to study their youth-serving systems. Iowa selected four sites with varying demographics for review. The other study utilized the SOCPR in Ottawa, Canada. In this presentation we provide a summary of results and discuss reactions to the findings, implementation actions, and next steps. The SOCPR is a case study methodology designed to obtain information from families, their formal service providers (case managers, therapists and other providers), and informal helpers concerning service planning, service delivery, child and family progress, and satisfaction with services. The SOCPR presents a measure of how well the needs of children with serious emotional disturbance and their families are being met by documenting their experiences in four domains: (a) child centered and family focused, (b) community based, (c) culturally competent, and (d) impact. Each child and family contributes a unique evaluation of the system of care.

Iowa's Children's Mental Health System Evaluation utilizing the SOCPR

Presenting: Stephen R. Roggenbaum, Victoria L. Hummer & Pamela R. Alger

Introduction

In the summer of 2007, the Iowa Department of Human Services (DHS) and the University of South Florida's Louis de la Parte Mental Health Institute (FMHI) began a collaboration to evaluate the current system of care for children experiencing mental and emotional disorders in the state of Iowa. The goal was to gain a "baseline" of the children's mental health delivery system through a methodology known as the System of Care Practice Review (SOCPR) and to generate system-level and practice-level recommendations for improvement based on the system of care framework. The SOCPR presents a measure of how well the needs of children with serious emotional disturbance and their families are being met by documenting their experiences in four domains: (a) child centered and family focused, (b) community based, (c) culturally competent, and (d) impact. Each child and family contributes a unique evaluation of the system of care.

Methodology

Four Iowa sites with varying demographics were selected for review: (1) Des Moines/Polk County; (2) Clinton/Clinton County (part of the existing CMHI); (3) Clarinda/Page, Fremont, and Montgomery Counties; and (4) Le Mars/Plymouth, Cherokee, and Sioux Counties. The reviews took place between October and December 2007. A total of 43 case studies were completed; each case included 2-4 interviews per case.

Cases were selected to represent the range of ages of children served, the types of cases, and to represent the agencies providing services to children with emotional disturbance and their families.

Findings

Practice Level

For the domain, *child centered and family focused*, positive findings included the inclusion of assessment findings in service plans, active participation of youth and family in service plan development, and coordination of the planning and delivery of services. Challenges were the omission of some life domains in assessments, a lack of integration across multiple plans for the same child and family, and relatively little identification and use of child and family strengths or informal helpers in service plans.

For the domain, *community based*, there were high ratings in the areas of convenience, scheduling, and comfort with the service location, which was usually in the home. Caregivers expressed that in general, communication was positive and frequent between themselves and the case coordinators and providers. System responsiveness at the time the child first began experiencing problems was viewed as a challenge. Providers stated that in rural communities, they often had to see families on the one day a week that they were at a designated site, which did not allow for flexibility of scheduling around missed appointments. Contracted providers were also not reimbursed for travel time, adding to the difficulty in retaining and maintaining experienced respite and in-home providers.

The greatest challenge to communities statewide was in the area of *cultural competence*. Caregivers, providers and stakeholders alike were hesitant with regard to their responses to many of the questions that defined culture as a lifestyle, along with concepts of health and family, race and ethnicity. There was little awareness that one might view clients' culture as a potential asset in service delivery. Understanding the dynamics of working with same and different cultures, being responsive to a family's culture, and turning cultural understanding into action were all rated negatively.

The final domain relates to the *impact* that services and supports have had on the child and family. The responses were rated highest in the area of improvement in the child's functioning, and slightly less positive regarding improvements in family functioning. The most frequent reason stated for not meeting families' needs was a lack of respite services.

Stakeholders

The FMHI/Iowa research team interviewed 33 key stakeholders during the four site visits for the purpose of gathering data about the status of the local and state systems. Interviewees included stakeholders in leadership and supervisory positions representing juvenile court,

community mental health clinics, residential treatment programs and inpatient hospitalization settings, crisis intervention services, community mental health, child welfare services, contracted service providers, public county schools, the system of care grantee in Northeast Iowa, the DHS Central Point of Coordination (CPC), and community health providers. Common themes were identified across interviewees including patterns, themes, and contradictions. The key stakeholder information complements the SOCPR case findings to provide a community context for the analysis.

Conclusion

The general conclusion from the case studies and key stakeholder interviews is that a holistic system of care for children with mental health needs and their families, with evidence of the implementation of the core values and guiding principles, is not currently in place in Iowa. There is commitment, some clarity, and collaboration among all stakeholders and providers that were interviewed. And, there is a sense of hope and anticipation for improvement. Yet dialogue continues to occur without a true “family voice.” The language still reflects an attitude of “doing for,” and “being committed to” families, rather than “doing with” them. Assessments and service planning were often more specific to the child’s needs, strengths, and goals with less emphasis on the family. The cultural identity of the family was not fully understood and/or viewed as an asset in the cultural domain, and the overall positive impact of the system on the family was viewed as less than the impact on the child. The report concludes with a list of recommendations at the system and practice levels.

Additionally, key stakeholder interviews conducted at each site verified the findings of the case studies and also highlighted the need for educational experiences and cross training for child serving systems, providers, and consumers.

A response from the Bureau Chief of Child and Adolescent Services, Mental Health and Disability Services, Iowa Department of Human Services will cover reactions to the findings, implementation actions, and next steps in Iowa.

Using the SOCPR to Facilitate System Transformation Efforts in Ottawa, Canada

Presenting: Natasha Tatartcheff-Quesnel, Francine Gravelle & Michael Hone

Introduction

This presentation will demonstrate how the System of Care Practice Review (SOCPR) was used to facilitate local transformation efforts in Ottawa, Canada. Specifically, the SOCPR was administered to 32 families within a one-year period in order to establish baseline data about the local children’s mental health system. The SOCPR itself and the resulting data served to strengthen and expand a local collaborative and became the foundation for a system planning and transformation process. Finally, the SOCPR and system of care values embedded in the tool have provided the community with an ability to operationalize the “Ontario Policy Framework” for moving policy into practice.

Methodology

The project consisted of 32 case studies that were chosen using a random yet representative sample of children/youth and their families identified by the community as having complex mental health needs. The case studies were chosen by Ottawa’s access mechanism, which provides case resolution and referral services for children and youth from 0-18 years of age (and their families) deemed “hard to serve.”

Findings

The results of the SOCPR case studies provided the community with a road map for the development of a community planning model to address the advocacy priorities, system improvements and community training needs to improve the effectiveness of Ottawa’s children’s mental health system. Many of the challenges identified were seen as an opportunity for change and improvement. Most important, the result of the systemic evaluation unified the community by providing a common language, collective goals and a shared responsibility in the transformation process. Finally, the SOCPR allowed the Ottawa community to move policy into practice by using the SOCPR as a mechanism for change and evaluation of progress over time.

For example, common priorities and system improvements in the area of case management and client data sharing were identified and acknowledged by all agencies, thus fostering a shared ownership in the transformation process. Specifically, it was identified that the system in Ottawa lacked a complete, comprehensive and funded approach to case management. Individual organizations would take on this important task; however, they would do so without the needed time and monetary resources to successfully manage a case. Also, clients identified a desire for service providers to share information more freely in order to reduce the need for them to repeat their story. As a result, the community identified the need to develop memorandums of understanding between agencies in order to facilitate the sharing of client information with the aim of improving client transitions.

In the area of training, it was recognized that attainment of multicultural competence could only be achieved through a commitment to on-going training, evaluation and assessment. To that end, a multi-year training plan was developed. Further, the use of family strengths in treatment/service plans was identified as training need. Service providers identified a challenge related to translating the identification of core/resiliency strengths and translating those into actions/goals contained within treatment/service plans.

The SOCPR has provided a road map that will enable organizations in the region to meet objectives outlined in the Ontario Policy Framework as defined by the provincial government hence moving policy into practice.

Conclusion

The community collaborative model will be shared to highlight an example of how the SOCPR can be used to develop a structure that supports system transformation. More importantly the results of the SOCPR provided the foundation for the community collaborative to begin the process of formally adopting the system of care values and becoming the first identified Canadian system of care. There is a great deal of excitement at the front line and at the level of decisionmaking and policy development to move forward with the use of the SOCPR as an ongoing mechanism for system evaluation, thus utilizing qualitative data to inform future decision making at all levels. That excitement is even more present as a result of development of a shared vision for Ottawa’s Children’s mental health system.

Session 31 » 10:45 - 11:15 am » Salon D

Communication and Interaction of Pediatricians with Systems of Care

Presenting: Kara S. Riehm

Contributing: Sylvia Fisher, Joseph Fruh & Tesfayi Gebreselassie

Introduction

The involvement of pediatricians in systems of care (SOCs) has long been recognized as severely limited. Very few referrals to SOC programs are made from pediatricians, and SOC programs report there is little communication between mental health providers and pediatricians regarding service planning, medication management, and care of children in these systems. Beginning in 2007, several newly funded SOC programs have made an effort to involve primary care providers in program and service planning. However, the extent to which pediatricians in funded communities are aware of services provided by SOC programs or interact with these programs is unknown.

The purpose of the Pediatric Survey of Child Mental Health Services was to investigate the role of pediatricians in SOC programs, to learn how pediatricians identify and refer children and youth with mental health needs, and learn more about the factors that facilitate and inhibit communication and interaction between pediatricians and mental health providers. The survey development and implementation process was guided throughout by a team of stakeholders in SOC programs, including representatives from youth, caregivers, service providers, project directors, and primary care personnel.

Methodology

Sample

The sampling frame for the study was constructed from a comprehensive list of pediatricians in the target areas, which were zip code areas of youth participating in the systems of care programs funded by SAMHSA between 2002 and 2004—a total of 29 sites located in 17 states, and two U.S. territories (Guam and Puerto Rico). The sample was proportionally allocated based on the total number of pediatricians in each community, such that a greater number of pediatricians were sampled from larger communities and a smaller number from smaller communities. This random stratified sample identified 675 pediatricians located between these zip codes; 351 (52%) pediatricians responded to the survey, a response rate similar to other surveys of pediatricians (Heneghan et al., 2008; Horwitz et al., 2007).

Instrumentation

The survey assesses educational background and training, knowledge of and involvement with local SOC programs, mental health screening and referral practices, medication management for mental health problems, communication with mental health providers, family and youth participation in mental health care, and attitudes toward mental health service provision. A paper copy of the survey was mailed to each respondent, who also were offered the option of completing the survey online.

Results

Only 11% of respondents reported being somewhat or very familiar with the national SOC initiative, and only 10.6% responded being somewhat or very familiar with the local SOC program. Of those reporting some knowledge of the local program, 27.3% ($n = 12$) reported making a referral to that program, and 18% reported having worked with any staff from that program in the past 12 months.

While the vast majority of pediatricians (86.5%) believe it is part of their job to remain in ongoing communication with mental health providers, only 69% reported doing so in the past 12 months, which

has important implications for inter-sectorial collaboration in SOC programs. Pediatricians were asked about their screening and referral practices to mental health providers generally. While the majority of pediatricians (75%) reported routinely screening for mental health problems and making referrals to mental health providers, pediatricians reported receiving feedback from mental health providers for an average of only 41% of referrals made. In addition, more than one-third of respondents (35%) reported not knowing what percentage of the children they referred actually received any mental health services. The most common (44.3%) method of feedback regarding mental health referrals was through the parent. Fewer reported often or always receiving written feedback from mental health providers (31.5%), while only 5% reported often or always receiving feedback through verbal communication from the provider.

Over half of participating pediatricians reported difficulty obtaining a consultation from or referral to child psychiatrists (54%) and a quarter reported difficulty accessing child psychologists (25%). Commonly reported barriers to obtaining consultation from or referral to mental health providers included: a shortage of providers in the area (83%); lengthy waiting periods for referrals (80%); insurance approval (73%); and, lack of adequate/timely feedback on patient status and progress from providers (63%). Increasing the number of providers (50%), ensuring insurance and reimbursement for services (37.6%), increasing funding for training (27.4%), and streamlining the referral process (25%) were the most frequently identified strategies to decrease barriers to mental health services.

Conclusions

Very few of the surveyed pediatricians were familiar with the federal system of care initiative, or with their local SOC programs. Even among those familiar with the local SOC program, relatively few have made referrals to the program. However, a majority of pediatricians surveyed perceive that a shortage of mental health providers exists within their area, indicating the need for greater communication about available SOC services in communities. In addition, pediatricians report a lack of feedback from mental health providers about referrals they have made to mental health providers. While pediatricians recommend increasing the number of providers to increase access to mental health services, the lack of communication between pediatricians and mental health providers indicates that merely increasing services may not be sufficient to increase pediatrician involvement in SOC programs. Study results provide considerable insight into how pediatricians can be more effectively integrated within the SOC community, both in terms of referrals and in the provision of a more integrated and appropriate service array for participating children, youth, and their families.

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Session 31 » 10:45 - 11:45 am » Salon D

Improvement for Youth with Disruptive Behaviors Provided Evidence Based Practices

Presenting: Charles Mueller, Ryan Tolman, Chad Ebesutani & Adam Bernstein

Introduction

As a field, we have developed efficacious treatments for many youth disorders. A common criticism of this work has been that these treatments might not generalize to actual clinical settings, might not apply to challenging comorbid cases and might not fit well into complex systems of care. As such, we need to develop ways to link knowledge gained from science to that developed from practice. One under-used method is to identify common elements of evidence based (EBS) programs and to study whether or not the application of these EBS practice elements contributes to client improvement.

This investigation examines the relationship between rate of youth functional improvement and the use of specific therapeutic practices. Using hierarchical linear modeling (HLM), we examined whether the amount of various practice elements per month predicted improvement. We then divided all practice elements into those that do and do not appear in the evidence base for disruptive behaviors and entered these predictors into the model simultaneously.

Method

Participants

Youth who received their first intensive in-home (IIH) treatment episode in Hawaii's Child and Adolescent Mental Health Division (CAMHD) between July 1, 2005 and December 30, 2007 and who met the following criteria were included: (a) diagnosis of a disruptive behavior disorder (conduct, oppositional-defiant, or DBD-NOS); (b) one or more completed Child and Adolescent Functional Assessment Scales (CAFAS; Hodges, 1998) between 45 days before and 225 days after the beginning of treatment episode (thereby capturing functioning around the first 180 days of IIH services); (c) the earliest included CAFAS total score was greater than 30; (d) at least one completed Monthly Treatment and Progress Summary (MTPS) during the six-month time frame, and; (e) the selected treatment lasted 90 or more days. The final sample utilized data from 197 CAMHD youth (129 boys and 68 girls) with a mean age of 13.04 years ($SD = 3.49$). Ninety percent of the sample had one or more additional diagnoses ($n = 178$).

Measures

About quarterly, case coordinators completed the CAFAS, a measure of youth's level of functional impairment. The MTPS is a monthly clinician report form measuring service format, service setting, treatment targets, clinical progress, and intervention practice elements (Nakamura, et al. 2007). Regarding practice elements, clinicians select all intervention strategies utilized with a given client and his/her family in the specified month from a list of 55 pre-identified choices (plus two write-in options).

Procedure

All available CAFAS scores within the expanded time period were organized into a person-period data set. Data from every MTPS during the time period were captured, combined and entered as time invariant predictors. In order to control for length of treatment (three to six months), the average number of practice elements per month (or per MTPS) were calculated. Specifically, we derived three inter-related predictors: (1) Total number of times any practice element was used/MTPS; (2) number of times EBS practice elements were used/MTPS, and (3) number of times other ("non-EBS") practice elements were used/MTPS.

The Hawaii CAMHD Biennial Report (CAMHD, 2007) provided data on the occurrence of specific practice elements in efficacious treatment protocols for disruptive behavior disorders, and was utilized to classify practice elements as "empirically supported" or not. Specifically, practice elements included once or more in treatment protocols for disruptive behavior disorders supported at Level 2 (Good Support) or higher (i.e., equivalent to the APA's "well-established" and "probably efficacious" levels) were classified as "empirically supported" for this study.

Results

Based on a restricted maximum likelihood HLM analysis, the addition of each new practice element per month significantly increased the rate of improvement/day ($Beta = -.004, p < .03$) over and above the base-rate. When we divided total monthly practice elements into EBS and "non-EBS" both measures of practice amount contributed to greater rates of improvement. However, when EBS and non-EBS elements were entered simultaneously (thereby controlling for shared variance), the EBS variable continued to predict greater improvement rates ($Beta = -.009, p < .05$), while the remaining practice elements did not (indeed the direction of the effect reversed, but was not significant). Said another way, each additional EBS practice element/month increased the overall rate of improvement by 13% (EBS $Beta = -.009$ /Baseline $Beta = -.07 = .13$).

Conclusions

The present findings indicate that greater use of various practice elements was associated with increased rates of youth functional improvement and that this overall practice element effect was primarily due to increased use of EBS-based practice elements.

In order to control for any overall service dosage effect, we conducted a subsequent analysis where we entered data on the total number of days the youth received services during the treatment episode along with the practice element variables ($n = 195$ due to missing data on two cases). Again, we found effects for total practice elements and EBS-based practice elements, even after controlling for dosage.

While there are limitations, the findings point to the potential importance of EBS practices in the improvement of disruptive youth in usual care. Given measurement problems, comorbidity (e.g. some "non-EBS practices" are "EBS" for another disorder), and other potential factors influencing rates of improvement, the present findings might well underestimate effects. Clearly more such research located in systems of care will help us understand the role of such practices and, ultimately, help us link the worlds of empirically based services and complex systems of care.

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Session 32 » 10:45 - 11:15 am » Salon G

Trends, Challenges & Opportunities in Conducting Culturally-Sensitive Evaluations of Child Mental Health Programs

Presenting: Alisha Nichols Johnson, Monica Mitchell & Jessica Valenzuela

Contributing: Kenneth Gilyard, Jennifer Allen & Jennifer Armstrong

Introduction

There is a growing demand for culturally-sensitive and methodological-sound evaluations that assess impact, sustainability and generalizability of programs and projects. Yet, there are also constraints to ensuring cultural sensitivity and best practices, including institutional and staff capacity, limited technological savvy and limited time and expertise to develop a feasible, cost-efficient and methodologically rigorous evaluation plan. Changing political agendas at federal and state levels offer opportunities and timeliness for redesigning and refocusing targets and outcomes that better capture unique cultural, social, developmental, and mental health outcomes in child prevention and intervention programs. In light of current and emerging guidelines, community agencies will be required to demonstrate program effectiveness and fiscal accountability through achieving program outcomes and positive impact at the same time that agencies will need to be culturally-responsive and sensitive to the needs of the population that it serves.

Methods

The goal of this presentation is to illustrate how culturally-sensitive program evaluations can be designed and administered to assess the effectiveness of child mental health programs. Specifically, this presentation will provide examples of program evaluations in an effort to (1) highlight trends, challenges and opportunities related to culturally-sensitive/real-world program evaluation and (2) describe evaluation strategies that ensure cultural-sensitivity when evaluating child mental health programs and services.

A. Winning Beginnings

The Winning Beginnings Initiative spans across 16 sites in the Greater Cincinnati area to promote positive social, emotional and cognitive development in preschool children. The program is designed to integrate coaching and mentoring with results from assessments including the Brackens and Ages, Stages and Get-It-Got-It-Go to help teachers understand and support the healthy development of children. INNOVATIONS facilitates learning circle meetings and trainings for teachers and directors as well as provides technical assistance and consultation in collaboration with Success By 6, 4C, Cincinnati Public Schools and Cincinnati Early Learning Centers.

Trends. Professional Development and Staff Training are also often used as methods to ensure that programs improve services and programs. Winning Beginnings provides teachers and program administration with training that will directly impact the culture of the environments in which they serve children.

Challenges. The primary challenge for this project was changing the culture of evidence-based instruction including compliance with data entry and aligning curricula or school programs. The program also found it difficult to develop common and/or shared outcomes across all participating sites, measures and databases, and aligning reporting cycles. Additional obstacles are developing steps and finding the time to improve the culture of an environment after training.

Opportunities. Training opportunities empower agencies to change culture while providing the most up-to-date methods for administering programs. For Winning Beginnings, training opportunities have become so popular that the number of classrooms will double next year at almost every center.

B. Center for Closing the Health Gap

INNOVATIONS in Community Research and Program Evaluation served as primary evaluator for the Do Right! Norwood project geared toward increasing the awareness of health disparities, maximizing collaborative opportunities and developing a research network to collect local data on health within the targeted Hispanic community.

Trends. Literature recommends that when developing culturally-sensitive survey instruments, researchers should solicit the input from stakeholders and service recipients to integrate cultural customs, language, beliefs and/or other nuances into conventional program evaluation designs and tools. This project invited Hispanic community members to participate in certain aspects of the evaluation including survey development.

Challenges. As with many evaluation tools, the Norwood project survey was designed as a self-report instrument. Despite community and cultural input in the survey development, there may have been challenges with item interpretation and/or sensitivity about certain aspects of the survey, causing respondents to be reluctant to answer questions.

Opportunities. Evaluators should consider developing culturally-sensitive instruments that include language, customs, beliefs and other aspects of culture that can be used to help build validity and trust in community research and evaluations.

Strategies

Strategies for ensuring cultural-sensitivity in program evaluations include:

1. Determine the need and identifying the goals for a culturally-sensitive program evaluation.²
2. Solicit the input of stakeholders of diverse, yet relevant backgrounds.²
3. Develop an evaluation plan that will capture and highlight any key differences or nuances between and/or within groups.¹
4. Develop evaluative instruments that reflect the program as well as the cultural diversity (socioeconomic status, race/ethnicity, language, customs, beliefs, communication styles, etc.) and values of the population served.¹
5. Administer the evaluation instruments in a manner that is non-threatening to cultural differences.
6. Analyze and interpret data using appropriate cultural contexts.
7. Report findings to all stakeholders including funders, staff, parents and community members.

Discussion

The community organizations that were illustrated provide examples of culturally-sensitive program evaluations as they relate to child mental health programs. Trends, challenges, opportunities and strategies were presented to provide evaluators with steps to ensure that cultural contexts are considered when evaluating the effectiveness of child-focused programs in the future. In light of emerging mental health needs of children, best practices in evaluation and mental health, and changes in child mental health and educational policies, a futuristic perspective of evaluating child mental health programs must be considered. Although integrity and confidentiality when conducting program evaluations will remain highly valued when collecting, storing, analyzing and reporting data, program reporting guidelines may alter due to stakeholder interests and/or funding requirements. Consequently, child mental health agencies should anticipate that the demands for culturally-sensitive program evaluations, fiscal accountability, community and parent involvement will increase despite unpredictable conditions.

Reference List

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² Frierson, H. T., Hood, S., & Hughes, G. B. (2002). Strategies that address culturally-responsive evaluation. In Frechtling, J., *The 2002 user-friendly handbook for project evaluation*. National Science Foundation.

Session 32 » 11:15 - 11:45 am » Salon G

Financing and Sustainability in American Indian and Alaska Native (Tribal) Systems of Care

Presenting: Holly Echo-Hawk, Anna Krivelyova & Carolyn Lichtenstein

Introduction

The national evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program recently completed an exploratory study examining the financing opportunities and challenges of Tribal systems of care. The purpose of this study was to examine the unique financing opportunities and challenges of Tribal systems of care in relation to program sustainability. The overall goal of collecting the information from this study was to identify and improve financing and sustainability strategies specifically appropriate for Tribal communities. This paper presents key findings from this study and relates them to data collected from Tribal system of care staff participating in the national evaluation's Sustainability Study, which examines funded communities' plans to sustain key components of their systems of care.

Methodology

The Exploratory Description of Financing and Sustainability in American Indian and Alaska Native (AI/AN) System of Care Communities (Tribal Financing Study) was conducted in 2007 and 2008. The national evaluation team facilitated discussions with 15 Tribal system of care communities funded by CMHS between 1994 and 2006. Telephone discussions with the project director and fiscal manager of all 15 communities covered broad thematic areas that included perspectives on sustainability; the economic, social, and political environment; infrastructure; services; and funding. Site visits were later conducted with five Tribal system of care communities and involved discussions with the project director and fiscal manager, a Tribal Board or Council representative, and a State representative. The discussions with State representatives focused on State agency support for Tribal systems of care. A Native researcher conducted all discussions in a culturally competent manner; respect for AI/AN historical concerns about data gathering and analysis guided the entire research process.

The Sustainability Study involved a web-based survey with respondents from system of care communities funded in 1999-2000 and 2002-2003, of which six were Tribal; there were 22 respondents from the Tribal communities. The survey was administered in late 2005. The survey lists system of care services and asks to what extent the services were available during and post funding. The survey also included a list of general sustainability strategies and a list of specific financing strategies; respondents indicate whether each strategy was used and, if so, how effective it was on a 5-point scale from "not effective" to "completely effective."

Findings

The Tribal Financing Study produced many useful findings. The qualitative analysis of the discussions produced nine domains within which successful strategies and challenges were grouped:

- **Planning for Sustainability** (e.g., having Tribal elders help design strategies to infuse Tribal values, practices, and cultural supports throughout the system of care)
- **Political Entities and Sustainability** (e.g., educating government funding sources about the importance of Tribal-driven services)
- **Developing Sustainable Services** (e.g., investing in training and credentialing programs for Tribal behavioral health staff)
- **Strengthening Infrastructure** (e.g., contracting with a public accountant to review the accounting system)
- **Role of Data in Financial Sustainability** (e.g., receiving technical assistance from the State regarding State databases)
- **Assessing and Mobilizing Funding Sources** (e.g., becoming knowledgeable about funding available in all States or regions affecting Tribal youth)
- **Determining the Cost of Services** (e.g., conducting time and cost studies)
- **Medicaid as a Funding Source** (e.g., developing relationships with State Medicaid officials)
- **Developing and Sustaining Key State Partnerships** (e.g., developing a working relationship with a key State administrator)

Responses from the Sustainability Study indicated that the general strategy used most often by Tribal systems of care was "cultivating strong interagency relationships." Respondents also indicated that involving stakeholders, providing training on the system of care approach, generating political and policy-level support for the system of care approach, and establishing a strong family organization were used frequently. The strategy reported as being used least was making policy/regulatory changes that support the system of care approach. Additional analysis will include comparison of sustainability strategies of all Tribal sites to that of non-Tribal sites.

The five most frequently used strategies were also rated as being at least moderately effective (i.e., among "moderately effective," "very effective," or "completely effective.") by approximately three-quarters of respondents. However, within this group of strategies, providing involving stakeholders and establishing a strong family organization were seen as substantially more effective than cultivating strong interagency relationships and generating political support.

Regarding specific financing strategies, respondents reported that the most frequently used strategies were operating more efficiently through cutting costs, leveraging funding sources, and increasing the ability to obtain Medicaid reimbursement for services. However, these strategies were not rated as being very effective. Administrative claiming (that is, using available child welfare and Medicaid funds to cover administrative costs), de-categorizing funding streams, charging fees for services, and creating new revenue by pursuing an activity unrelated to the system of care mission were the strategies least used.

Although more than 80% of the respondents reported that cost cutting was used as a financing strategy, 82% also indicated that the cost-cutting strategy was only somewhat or moderately effective. Similarly, although leveraging funding sources and increasing ability to obtain Medicaid reimbursement for services were attempted frequently, 78% of the respondents indicated that leveraging funding sources was no more than moderately effective. Regarding the ability to obtain Medicaid reimbursement for services, 90% of the respondents indicated that their ability to obtain Medicaid support was no more than moderately effective.

Conclusions

The findings of the Tribal Financing Study and the Sustainability Study each provide insight into the factors that impact the financial sustainability of the American Indian and Alaska Native systems of care. The findings from the Sustainability Study support the cultural complexities affecting the financing of a culture-driven system of care that were detailed in the Tribal Financing Study. For example, an emphasis on services in Tribal communities with limited human capital may result in diverting energy from building infrastructure, integrating the system of care with Tribal economic development efforts, and moving to the next level of advanced financial planning.

Session 33 » 10:45 - 11:15 am » Salon H

System-of-Care and Usual Services in the U.S.: Comparing Service Outcomes

Presenting: Kathleen Pottick & Ramona Perry

Introduction

Benchmarks provide critical information to which future utilization patterns may be compared, and efforts to deliver improved services to children may be evaluated. Children's System of Care (SOC) initiatives are now about 20 years in the making (Stroul & Friedman, 1986), but there is little national information about the success of implementation goals. With a 1997 nationally representative mental health service utilization data set, this study provides baseline information on SOC aims, ten years post-implementation.

The goals of the National Institute of Mental Health (NIMH) Child and Adolescent Service System Program (e.g., Stroul & Friedman, 1986) suggested that hospitalization should be replaced by a specific mix of home-based and community services. Services should be coordinated and integrated around the needs of each adolescent and should be built on partnerships between professionals and parents. In addition, a single team of providers or a case manager should have continuing responsibility for each adolescent over time (Lourie & Isaacs, 1988). Finally, whenever possible, adolescents should live at home, services should be provided in intensive, non-residential outpatient or community settings, and services should be sensitive to cultural differences.

The specific research questions are:

1. How many youth in U.S. mental health services receive SOC services?
2. What are the sociodemographic and clinical characteristics of youth in SOC compared to those in usual services?
3. Controlling on demographic and clinical characteristics, what is the effect of SOC versus usual services on service delivery outcomes?

Answers to these questions will provide national estimates of SOC penetration, describe the characteristics of youth accessing SOC services, and provide insight into the extent to which the following two stated hypotheses on service delivery outcomes were confirmed: Controlling on demographic and clinical characteristics, (1) youth in SOC will be more likely to receive outpatient services rather than inpatient services than youth in usual care, and (2) youth in SOC will be more likely to receive case management, education, family and individual therapy, and screening services than youth in usual care.

Method

Data Source and Sample

The 1997 CPSS was conducted by the National Institute of Health's Center for Mental Health Services to collect statistical information on persons receiving specialty mental health care throughout the nation (for

design detail, see Milazzo-Sayre et al., 2001). The study targeted two distinct populations; (1) all persons who were admitted to or discharged from inpatient, outpatient and residential treatment facilities during 1997 and (2) all persons under care in these facilities on May 1, 1997. Prevalence estimates are based on admissions data (unweighted $N = 4035$). Services received were recorded only in the under care sample ($N = 4014$). CMHS calculated weights to generate national estimates from sample counts.

Variables and Measures

Three dependent measures were used: (1) whether the youth was admitted to inpatient versus outpatient care, (2) type of service received, measured by 5 discrete dichotomous variables (services = clinical case management, education, family and individual therapy, diagnostic/intake), and (3) total number of services, a sum of the 5 services for each youth.

The primary independent variable was SOC participation. The survey included a measure of whether (1) or not (0) the youth was in a SOC.

Sociodemographic characteristics included age, gender, race-ethnicity, and payment source. Clinical characteristics included the Global Assessment of Functioning (GAF), principle diagnosis (ICD-9 or DSM), presence of a secondary or dual diagnosis, presenting problem of suicidal thoughts or behaviors, and referral source.

Analytic Procedures

Basic frequency, t -tests and chi-square analyses were used to compare the characteristics of youth admitted for SOC and usual services, and to examine differences in service receipt (type and mean number) by SOC participation. For the presentation, multivariate logistic regression methods on weighted data with standard error adjustments will be used to estimate the association between SOC participation and (1) inpatient versus outpatient care, and (2) clinical case management (CCM), chosen because it is one of the essential services within a SOC (Stroul & Friedman, 1986).

Preliminary Results

In 1997, nearly half (47.1%) of the mental health service population in the United States were admitted in SOC, representing a national estimate of 621,682. (Table 1). SOC youth had worse clinical profiles, were more likely to be referred from social service and community settings, and were to receive care paid with public dollars. There were no significant race-ethnicity or age differences in youth admitted to SOC or usual services, but SOC youth were more likely to be admitted to outpatient or residential services, while non-SOC youth were more likely to be admitted as inpatients. (All reported chi-square tests at $p < .05$).

Table 1
Characteristics of Youth (0-17 years) Admitted to System of Care and Usual Services,
1997 U.S. Estimates (unweighted N = 4035)

	<i>System of Care</i> <i>Weighted N (%)</i> <i>621,682 (47.1)</i> <i>%</i>	<i>Not System of Care</i> <i>Weighted N (%)</i> <i>697,040 (52.9)</i> <i>%</i>
Demographics		
Race/Ethnicity		
Non-Hispanic White	64.6	64.6
Non-Hispanic Black	18.6	19
Hispanic	14.7	13.9
Other	1.9	2.3
Age		
Under 6	8.3	9.7
6-12 Years	38.4	41.9
13-17 Years	53.3	48.3
Gender*		
Male	57.2	53.8
Female	42.5	46.1
Payment Source***		
Medicaid	48.2	39.3
Public Source, State Dept. or Social Service Funds	14.6	7.76
Commercial Health Insurance	25.8	35.3
Personal Resources	5.19	12.6
No Fee	6.16	4.8
Clinical Factors		
Global Assessment of Functioning**		
Severe Disturbance < 50	46.14	37.6
Moderate Disturbance 51-60	31.1	32.9
Mild Disturbance > 61	22.7	29.3
Primary Diagnosis***		
Mood Disorders	23.4	18.4
Anxiety Disorders	7.5	7.4
Psychotic Disorders	3.5	1.7
Personality Disorders	2.2	1.8
Attention Deficit Disorder	14.2	14.0
Conduct Disorder	17.3	16.1
Adjustment Disorders	14.1	18.3
Alcohol and Drug Disorders	3.7	2.9
Developmental and Pervasive Disorders	5.0	5.3
Social Conditions	3.0	4.1
Other, Medical, Deferred, Unknown	5.6	9.3
Presenting Problem: suicide**		
Yes	27.7	20.6
No	72.3	79.4
Dual Diagnosis**		
Dual Diagnosis	61.8	70.7
No Dual Diagnosis	38.1	29.2
Referral Source***		
Family/Friend; Self	28.8	41.8
Social Service; Community	21.4	12.6
Justice System	10.6	8.6
Educational System	9.6	11.1
Outpatient Setting	16.1	17.1
Inpatient Setting	13.5	8.8
Program Service Setting*		
Outpatient	23.2	20.3
Inpatient	70	76.2
Residential	6.7	3.4

Note: This analysis was conducted on the admissions sample. Chi-square tests of significance were conducted on the weighted data with SUDAAN to account for the complex survey design by adjusting for the standard error of the estimates.

Table 1 shows the distribution of the five services, and demonstrates that SOC youth receive proportionately more of all but one service compared to non-SOC youth. However, the levels of receipt for these services within a SOC were relatively low. SOC served less than half of its admitted youth in each service but individual therapy, and CCM was received by only 46% of youth.

Preliminary multivariate logistic regression analyses (not tabled) on the unweighted data were conducted to investigate the association between SOC participation and CCM receipt. It showed that SOC participation remained a statistically significant predictor of CCM receipt even after controlling for other characteristics. For the presentation, these preliminary findings will be examined on weighted data, and analyses on SOC participation and inpatient versus outpatient care will be conducted.

Discussion

To our knowledge, this is the first study to use nationally representative data to examine the prevalence of SOC use in the U.S., to compare the characteristics of youth admitted for care, and to assess SOC aims for the nation. Results show that about half of U.S. youth in the mental health delivery system are receiving SOC services; they tend to have more clinical need and receive more targeted services than those in usual care. As targeted services are received by less than half of the SOC population, there is room for improvement. Implications for future regional and national benchmarks will be discussed.

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Session 33 » 11:15 - 11:45 am » Salon H

Multilevel Framework for Integrating the Formative and Summative Functions of Evaluation in Mental Health

Presenting: Ana Maria Brannan

Acknowledgements: I would like to acknowledge the contributions of the program staff at the commUNITY cares system of care to this work. Special thanks to Heidi Nelson, Kim Gray, Mona Gauthier, Sharon DeBerry, and Mohua Hazra for their fine insights.

Introduction

Program evaluation must often satisfy both formative and summative functions. The goal of formative evaluation is to use data to improve the organization and practice of interventions locally. Summative evaluation aims to improve the knowledge base, providing evidence of the effectiveness of one intervention over another by using information collected longitudinally. Formative evaluation is best conducted using participatory approaches with stakeholder involvement at every stage of the process. Summative evaluation is bound by the rules of research and science and requires a more “objective” process. There is a long acknowledged tension that emerges when formative evaluation efforts compromise summative functions, and vice versa. As a result of this tension, many practitioners and policymakers find the work of evaluation researchers does not inform their decisions, and evaluation researchers devalue local efforts to understand service and system as unscientific (c.f., Rossi & Freeman, 1993).

To resolve these tensions in children’s mental health services, we have developed the Framework for Integrated Formative and Summative Evaluation. This model was designed to use information to improve services locally without compromising summative functions that inform policymakers and contribute to the development of the larger research base. Table 1 provides examples of areas that can be examined in efforts to evaluate reform of child mental health systems. These areas are organized by level of assessment (i.e., youth, family, service/provider, and system) and stage of assessment (i.e., immediate, proximal, and distal). In this discussion, I illustrate how this framework can be used to assess the practice and impact of wraparound on outcomes (Walker & Schutte, 2004). However, each community should identify important elements to examine and develop its own priorities in a collaborative process among key stakeholders (e.g., family representatives, practitioners in multiple agencies, state administrators).

Levels of Assessment

One can imagine these levels as concentric circles. At the center of the treatment process is the youth who is struggling with emotional, behavioral and/or substance disorders. The youth exists in the larger context of the family that shapes whether formal mental health services will be pursued for the youth and how the service process will proceed. Families and youth are served within a network of providers that also influences the therapeutic process. Providers operate within a larger system that structurally defines how services will be delivered.

Individuals at each level offer different types of information that serve different purposes. For example, only parents/caregivers can report the extent to which they were able to participate fully in their youth’s treatment or how satisfied they were with services they received. Program directors, other administrators and family members involved at the system level are better suited to informing how well agencies work together to create an infrastructure that promotes collaboration. By distinguishing levels of assessment, we can better discern what type of data is needed to inform topics at each level and to identify who the best informants are for reporting that data.

Table 1
Framework for Integrated Formative and Summative Assessment:
Examples of Potential Areas to Assess at Various Levels and Stages of Assessment

Stage of Assessment/Evaluation				
		Formative		Summative
		Immediate	Proximal	Distal and/or Aggregated
Level of Assessment/Evaluation	Youth	<ul style="list-style-type: none">• Involvement in treatment planning• Therapeutic alliance	<ul style="list-style-type: none">• Completeness/appropriateness of treatment plan• Youth assessment of treatment planning process• Assessment of child-level obstacles to completion of treatment & adherence to tx recommendations• Review of individual child progress	<ul style="list-style-type: none">• Assessments of child mental health and substance use over time• Assessments of child social functioning over time• Assessment of child strengths over time• Assessments of quality of life over time
	Family	<ul style="list-style-type: none">• Involvement in treatment planning• Interaction with Family Partner• Participation in child's treatment• Parent-provider collaboration• Access to family support services	<ul style="list-style-type: none">• Parent assessment of treatment planning process• Parent assessment of Family Partner services• Parent perceptions of interactions with providers/services• Assessment of family-level obstacles to completion of treatment & adherence to treatment recommendations	<ul style="list-style-type: none">• Assessments of caregiver strain over time• Assessments of family life over time• Assessments of quality of family life over time
	Service/provider	<ul style="list-style-type: none">• Fidelity to treatment planning process• Parent-provider collaboration• Working collaboratively with other agency staff in the care of a give child/family	<ul style="list-style-type: none">• Provider assessment of treatment planning process• Assessment of provider-level obstacles to completion of treatment & adherence to treatment recommendations• Assessment of obstacles to multi-agency collaboration• Provider reports of how they use feedback data	<ul style="list-style-type: none">• Child and parent ratings of satisfaction service process and overall system• Relationship between use of feedback and quality of care• Parent perceptions of cultural competence over time• Service use patterns and their relation to child and family outcomes
	System	<ul style="list-style-type: none">• Inter-agency collaboration at system level• Parent participation is system development/management• Training of providers• Quality improvement (use of data/information for system improvement & performance assessment)• Strategic planning	<ul style="list-style-type: none">• Stakeholder reports of interagency collaboration• Parent reports of participation in system development/management• Stakeholder assessment of how well data feedback system leads to service & system improvements• Review meeting of concept mapping goals• Strategic plan review	<ul style="list-style-type: none">• Reports of system/service improvement process• Review costs of services across system

Stages of Assessment

“Stages of assessment” refers to the distance from the events designed to achieve the desired goals. At the youth, family and provider levels, the goal is to ameliorate the child’s emotional, behavioral and substance abuse disorders. The events to meet that goal include activities such as service planning meetings, clinical therapy sessions, and parent behavior management training, among many others. According to the framework, assessment of those events should occur at the “immediate” stage to assess the actual process of care. Assessment at the “proximal” stage is designed to assess the extent to which services are being delivered according to the program theory, in general (e.g., whether key events have occurred as planned across multiple families). For example, at the immediate stage, we could assess the extent to which the caregiver was involved in her child’s service planning process in accordance with system of care principles. At the proximal stage, we would assess family involvement in the wraparound process across caregivers over a short period time (i.e., aggregated data over a few months). We might also be interested in whether family involvement was related to better implementation of the wraparound plan (i.e., were services actually received as planned). At the “distal” stage, assessment efforts are designed to inform the broader policy context and build the research base. Following the wraparound example, efforts at the distal stage might inform whether good family involvement in the wraparound process led to better child and family outcomes over time. At this stage, recruitment of participants, instrumentation, longitudinal data collection, and analysis must comply with rigorous research methods. Data collected using established instruments with demonstrated psychometric quality are aggregated across youth, families, providers and other stakeholders. Data collection at the distal stage typically takes months or years to recruit sufficient numbers of participants and to follow them over time.

Timeframes for Targeted Feedback

The stage of assessment has important implications for the information feedback timeframe. Information gathered at the immediate and proximal stages need to be fed back quickly because it is used to improve currently ongoing care and routine processes. The summative evaluation process at the distal stage is necessarily a longer feedback loop limiting its usefulness for informing ongoing care.

Keeping with the wraparound example, important findings from observation of wraparound meetings (e.g., the extent to which providers encouraged caregiver participation) would be immediately (within a couple of days) provided to the service providers involved in order to identify problems that need to be addressed with that client and help providers fine-tune their own practice. This would occur much as clinical supervision would.

Data on caregiver perceptions of their participation in the wraparound process that was collected at the proximal stage would be aggregated over a few weeks or months to provide a picture of families’ collective experiences. That type of information could point to changes that need to be made at the program or system level to improve parent participation in the wraparound process (e.g., additional training of providers).

The feedback timeframe is much longer at the distal stage, and follows more formal dissemination avenues. Reports summarizing primary findings are provided to federal and state administrators and legislators to inform broad policymaking. Research articles are disseminated through scientific journals. The analysis and manuscript development process takes several months and the peer review process and publication can take over a year. The purpose of distal stage information is to contribute to the knowledge base and shape future intervention and broader program development efforts. It is not expected to inform local efforts very well because of the lag time in dissemination.

Wraparound Assessment Example

Aspects of this framework are being applied in a CMHS-funded system of care community serving youth 10 to 18 years old who have emotional and behavioral disorders and substance misuse problems and their families. This community is using the wraparound service approach to plan services and monitor provision of care and wanted to: 1) provide on-going monitoring and supervision of wraparound processes to improve practice, and 2) understand how the wraparound process was impacting child and family outcomes. To meet the practice improvement goals, we needed a flexible process that could respond to the day-to-day realities of service provision. To examine the impact on children and families, we needed a more rigorous process that met established research standards. To meet both of these goals, we are taking a multi-pronged approach that build on each other to provide a broader perspective on the wraparound process as it is practiced in our community. Research questions for this work are:

- To what extent does fidelity to the wraparound process improve with feedback?
- To what extent does implementation of service plan improve over time?
- To what extent do outcomes vary by fidelity to wraparound process?

Immediate Stage: Practice Improvement. We chose an observational approach to aid the monitoring and supervision of the wraparound process. We modified the Wraparound Observation Form (WOF; Epstein, et al., 1998) to reflect the language and procedures used locally. Over a two week period, two wraparound supervisors assess the same wraparound meetings and rated the process using the WOF. Following the meeting, the supervisors compare their ratings. They discuss differences in their ratings and made decisions about how events should be rated. This is done to help calibrate the ratings across the supervisors and to reduce differences in rating. However, we do not concern ourselves with formal assessments of inter-rater reliability because the WOF data would not be used to examine summative questions (i.e., does good wraparound practice lead to better outcomes?). It is more important to establish a procedure that was locally relevant, easily administered, and sufficiently flexible to inform immediate practice.

After two weeks of “calibration,” supervisors will observe wraparound meetings and providing feedback to facilitators. It is important to provide quick feedback while the details are still fresh in the facilitators’ and supervisors’ minds. Hence, supervisors meet with facilitators soon after the assessed session. In the supervisory session, the meeting is discussed, highlighting strengths and areas of improvement, and troubleshooting identified problems. At this immediate stage, we do not take the time to enter and summarize the WOF. A copy of the WOF rating is given to the facilitator for reference.

Proximal Stage: Practice Assessment. In order to assess the wraparound process for evaluation research purposes, a more formal approach needs to be used. At this proximal stage, procedures should be more scientifically rigorous and IRB approval is required. Our plans for this stage of assessment will gather different information from multiple informants.

To assess reliably the extent to which children and families are receiving wraparound services of good quality, we plan to use the Wraparound Fidelity Index (WFI; Bruns, et al., 2004). The WFI will be completed by the youth, caregiver and wraparound facilitators following the wraparound meeting. To protect confidentiality, these data will not be shared directly with facilitators and will only be reported in aggregate. Meetings for which the WFI is assessed need not be the same as those that are rated by supervisors using the WOF. However, it may be helpful to assess the some meetings with both instruments to determine the extent to which supervisor ratings agree with the ratings from youth, caregivers, and facilitators.

In addition to the WFI, caregivers, youth and facilitators will complete a measure of therapeutic alliance as another potential mediator of clinical outcome. This will help discern the extent to which improvements are related to good general practice. Also at the proximal stage, a sample of records will be reviewed to assess whether implementation of the service plans developed through the wraparound process is improving with feedback.

Finally, at this proximal stage, WOF and WFI data collected over time can be compared across and within facilitators to ascertain whether receiving WOF feedback improves wraparound practice over time. For a true test of this question, we would need to withhold WOF feedback from a randomly selected sample of facilitators for a period of time and compare WFI rating of samples.

Distal Stage. At the distal stage, we examine the extent to which good wraparound process is associated with improved youth and family outcomes. Families who participate in the proximal stage assessment (i.e., WFI and therapeutic alliance assessment) will be drawn from the sample who are already participating in the longitudinal outcome study of the national evaluation of the children's mental health initiative (Holden, et al., 2003). We will use clinical status data (i.e., symptom severity, psychosocial functioning) collected over time as part of the national evaluation to examine whether youth and families who received a better wraparound process and better adherence to the wraparound service plan also experienced better outcomes than those who did not.

Summary

If the supervision/monitoring data were intended to be used for summative purposes, a more rigorous process would be necessary. For example, we would need to concern ourselves with how "objective" the supervisors were in their ratings. We would also need to be stringent about inter-rater reliability of WOF assessments. We might not be able to give the facilitators direct feedback from individual WOF ratings, or provide them with a copy because we might be concerned that we would be "teaching to the test." In addition, we would likely need informed consent from families which would mean the care of some families would never be assessed. Because this effort was solely for clinical supervision purposes it would not typically be considered research and would not require IRB approval. All of these changes have the potential to make the process too cumbersome and less useful for the immediate stage purpose of improving clinical practice.

Because we can relax some of the rigor that would be needed if the WOF data were to be used for summative purposes, we can provide information that is more locally relevant and in a quicker time frame in order to maximize practice improvement. By using a separate instrument (i.e., the WFI) from different informants to assess practice at the proximal stage, we can apply a more rigorous approach to address summative questions without compromising the formative goal of improving practice. One might wonder why we would not choose to use the youth and caregiver ratings on the WFI to provide feedback to facilitators and avoid the extra effort of the WOF assessment. The problem with that approach is that we would need to insert procedures to protect the confidentiality of the information provided by youth and families or they would likely not feel safe to provide frank and honest assessments. These procedures (e.g., aggregating data across clients and reporting them as a group) would provide less precise information by not focusing on a specific meeting and would lengthen the time between the event (i.e., wraparound meeting) and the receipt of feedback because it would take more time to gather, enter, and analyze data on an aggregate sample of meetings. This shift from the immediate to the proximal stage would limit the usefulness of the data for improving ongoing practice.

Likewise, data collected for summative purposes (e.g., symptom severity and psychosocial functioning collected every several months over time) are so remote from the key event, that their usefulness for informing practice improvement is severely limited. These distal data can reveal whether our efforts are efficacious but provide no information about what to do to improve efficaciousness, particularly regarding the wraparound process. In addition, the length of time between the clinical event and the receipt of feedback is so long that it can in no way inform practice with a given family while it is ongoing. That is not to say that these data are not useful for informing broader questions in an organization or for the overall field. For summative purposes, we need reliable and valid data collected in rigorous ways to inform whether system goals are being met over time and across clients, as well as to inform the field about the effectiveness of certain treatment approaches over others.

It should be noted that there are also several nascent efforts to use clinical data collected with these summative-type tools to inform treatment progress at the immediate stage (e.g., Lambert, Hansen, & Finch, 2001). In these promising approaches, brief clinical assessments are administered at every treatment session and compared to data from a large sample of clients to determine whether the current client is progressing as expected. What makes these efforts useful for formative evaluation at the immediate stage is that the data are collected frequently and can be utilized immediately to inform practice with an individual client. This is very different than providing clinical information several months later for a group of clients.

In sum, decisions about what information to gather and how to collect it should be driven by the purpose of that information. By thinking through what those purposes are and what information would be most useful to inform those goals we can maximize the effectiveness of our evaluation and research efforts and avoid wasting time on activities that will not provide the information we need. This framework can be a tool in guiding that process.

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Session 34 » 10:45 - 11:15 am » Salon I

Social Connectedness of Families in Wraparound: Implications for Practice

Presenting: James Cook & Ryan Kilmer

Introduction

Ideally, wraparound involves a combination of formal and informal supports/resources, with the proportion of informal resources growing over time (VanDenBerg & Grealish, 1996). The involvement of informal or natural supports is critical in providing assistance that professionals cannot provide themselves, and to ensure continued access to supports after formal services are no longer needed. Although the importance of informal supports is widely recognized, substantial evidence indicates that professionals operating within systems of care (SOCs) have difficulties enlisting and engaging informal supports in wraparound service plans (Dalder, 2006).

The relative absence of informal, natural supports has been well documented. For instance, Epstein and colleagues (2003), found that only 33% of 112 child and family team (CFT) meetings included informal supports. Similarly, Davis and Dollard (2004) found that 32% of 118 CFT meetings (and 40% of plans) included informal supports, and Cook et al. (2007) reported that 29% of 98 CFT meetings included nonprofessional supports for youth and family. Other studies have shown similar results (e.g., Walker & Schutte, 2005). Most SOC's appear to place a much greater emphasis on professional supports than on those in the contexts of youth and families.

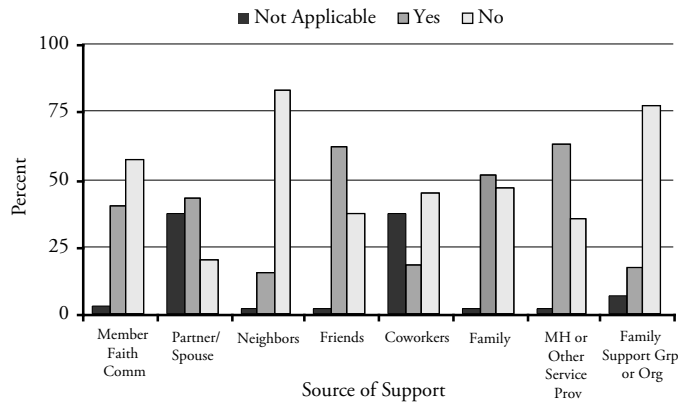
Multiple factors may contribute to the underutilization of informal supports in wraparound. Traditional mental health models rely upon professionals who provide formal treatments, and growing emphasis on "evidence based treatments" reinforces a tendency to view these as the core components of service plans. Furthermore, informal supports are not eligible for reimbursement, and may not fit into the business models of mental health service providers. Also, families may be unwilling to involve natural supports because of stigma.

Because informal supports are widely viewed as important, assessing the degree to which families are connected, and providing feedback to SOC's regarding the support that families experience, can advance practice. This paper reports on the use of the Assessment of Social Connectedness, which allows parents/caregivers to report on the provision of support from multiple sources—family, friends, neighbors, faith communities, mental health professionals, spouses/partners, family advocacy groups, and coworkers—and identify the level of different types of support (i.e., emotional, advice/information, financial, tangible, or crisis) received from each source. These questions were added to the national evaluation protocol, and have been administered to 60 caregivers. Based on these data, it is possible to identify the sources and types of supports families are most likely to receive, along with the patterns of support received by families. This presentation will also examine associations between social connectedness and neighborhood characteristics (e.g., perceptions of safety) as well as service utilization.

Results

As Figure 1 illustrates, approximately 37% of families report no support from partner/spouse or coworkers, and almost all caregivers report involvement with the other potential sources of support. The most frequently reported sources were service providers (63%) and friends (62%), followed by family (52%), partners/spouses (43%), and members of their faith communities (40%). Relatively few caregivers (< 20%) reported receiving support from neighbors, coworkers, or family support organizations.

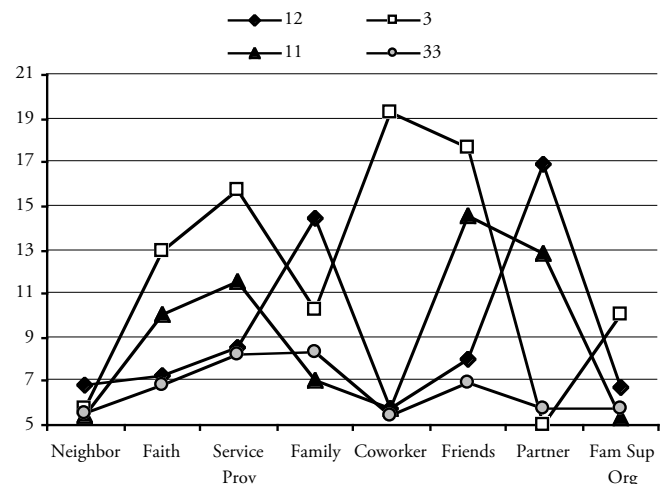
Figure 1
Received Support Past 6 Mo (n = 60)
Have you received *any* type of support or assistance from...?



Delineating the type of support from each source highlights that the caregivers receive different types of support from different sources. For example, a "great deal" of each type of support was reported from 48 - 55% of the partners/spouses; but only 13-39% of caregivers reported a "great deal" of support from service providers. Tangible and financial support were rarely reported for any source other than spouses/partners.

Cluster analysis identified patterns of support reported by caregivers (Zapata, Heidner, Wilkie, Cook, & Kilmer, 2008), and a 4-cluster solution identified distinct profiles reflecting the levels of support received from different sources (see Figure 2). Over half the 58 families reported very little support of any type across all sources (minimum = 5, maximum = 20). However, one cluster of 12 families reported receiving rather high levels of support from spouse/partner and family, but little elsewhere. Another very small cluster of 3 reported very high support from coworkers and friends, and moderate support from service providers and faith community. A fourth cluster of 11 families reported moderate support from friends and partners and less from other sources.

Figure 2
Sources of Support Clusters (N = 58)
5 = No Support; 20 = Very Much All 5 Types of Support



Most families are not, then, receiving support from community-based natural supports, and many receive little support from service providers. The present results suggest the need for placing a greater emphasis on connecting families with sources of support that can help them in the short run, and help sustain them in the long run.

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Session 34 » 11:15 - 11:45 am » Salon I

Selecting Residential or Community Based Care: Parent Survey Results

Presenting: Amy Starin

Introduction

The Individual Care Grant program in Illinois (ICG) offers parents of youth with psychotic disorders an opportunity to select either residential or intensive community based care for their child. This study sought to describe the factors parents considered critical in making these decisions as well as their actual decision making process. The study also sought to identify factors correlating with the selection of either location of care.

Methodology

A survey was developed, based on a thorough literature review, to identify potential factors that would impact a family's decision regarding location of care for their child. Ultimately 112 factors were included on the survey, as well as a rating for each factor identifying how important it was to the family in making the decision. The Columbia Impairment Scale was also included in the survey, which offers a framework for parents to describe their perception of their child's functioning. The survey was mailed to all parents who were recipients of ICG grants. A total of 467 surveys were distributed and 230 were completed by parents and returned anonymously, for a response rate of approximately 50%. The data was analyzed using distribution statistics, correlation, independent samples *T*-tests, chi square, regression and factor analysis.

Findings

Fifty-eight factors were weighted by parents to indicate how much they influenced their decision. Twenty factors were ranked by parents to be of 'moderate' or greater influence. The top three factors/questions that families indicated were most influential in making their decision, regardless of the location decision they made were:

1. What level of emotional distress have you experienced as a result of your child's mental illness?
2. Did you have to weigh the well-being of your child against the well-

being of other family members when you made the decision regarding care location?

3. When you made your last decision about care location, did you think there were professionals who could do a better job overall than you in caring for your child?

Forty items were identified with statistically significant correlations for families selecting residential treatment and those selecting community based care. Factors significantly correlating positively with the decision to place a child in residential care and negatively with the child receiving community based care were identified as well. The top six factors in terms of statistical significance were:

1. Thinking a professional could do a better job taking care of their child than they could.
2. Professionals recommending residential treatment.
3. Parents assessment of how helpful residential treatment would be.
4. Parents assessment of how big a problem the child had with getting in trouble.
5. Parents being afraid of the child.
6. Thinking that siblings would be better off if the child was placed in residential treatment.

Factors significantly correlating positively with the decision to place a child in community based care and negatively with the child receiving residential treatment were identified. The top six factors were:

1. Having hope that the additional community services available through ICG would make a positive difference for the family.
2. Medication being helpful to the child.
3. The child being able to celebrate holidays in a meaningful way with the family.
4. Having community based professionals that were committed to helping the parent keep the youth at home.
5. Having access to good quality therapeutic mentoring services.
6. The child was able to enjoy time with the family.

There were some surprises in factors that did not show patterns of relationship to either location of care. A few were:

1. To what degree did you have supportive people in the neighborhood, community or extended family that you could rely on for help with your child when you were at the point of making this decision?
2. Has your child physically injured themselves as a result of their mental illness?
3. Did you miss a significant amount of work in order to care for your child?
4. At the time you made the decision regarding care location, to what degree did you have access in your community to other professionals, such as counselors and social workers, who were experts in mental health care for children like your child?

Factor analysis identified five factors that grouped related items on the survey. The five factors were:

1. Child's level of functioning
2. Parent assessment of risk and benefit to the child and family of RTC placement
3. Child & family involvement in community life
4. Availability of community supports
5. Community support was experienced as insufficient

Taken together, regression analysis shows that they can successfully predict the decision a parent made about the child's location of care 83% of the time.

Parents also described their experience of making the decision. Sixty percent of families reported that this was either an 'extremely difficult decision' or the 'most difficult decision' they had even made. They further describe it as 'heart-breaking' and 'gut wrenching'. For families studied, placing their child in residential treatment was clearly their last resort.

Conclusion

The data from this study offer guidance for the provision of clinical care, policy development and education of practitioners. The logical manner in which these families made the decision about the location of a child's care strongly supports the concept of 'family driven care' in these critical decisions. The need for comprehensive support for family members in caring for these youth at home is a repeated theme in the data. Families need to be confident that providers are committed to helping them keep the youth home. This provides further support for the practice of wraparound services. Moreover, policy makers must recognize the financial strains on these families incumbent with maintaining children at home. Educators can utilize these findings to prepare community based practitioners to meet the needs these families identified, and when necessary, help them to make the choice to place the youth in residential care feeling confident that they have made a logical decision.

Session 35 » 10:45 - 11:45 am » Salon J symposium

The Statewide Implementation of Evidence-Based Practice: Outcomes and Lessons Learned from the Evaluation of MST in Connecticut

Chair: Jennifer Schroeder

Discussant: Robert Franks

Over ten years ago, the state of Connecticut began examining the behavioral health and juvenile justice services it provides to children and youth. A series of legislative and policy activities at that time led to the cultivation of a “fertile ground” for the dissemination of MST across the state. As a result, the first MST team in Connecticut was implemented in 1999 and early indicators suggested that this treatment was indeed effective with children and youth with substance abuse and behavioral disorders in Connecticut. From 1999 to 2006 the number of MST teams in Connecticut grew from two to twenty-seven. MST teams today serve approximately one thousand of the highest risk children and youth annually in Connecticut. This statewide implementation of MST is one of the largest-scale disseminations of in-home treatments in the nation. This symposium will present findings from a statewide evaluation of MST to help to answer the questions: “Is this treatment effective for Connecticut’s highest risk children and youth?,” “How is MST being implemented for Connecticut’s high-risk children and youth?,” and “What are the lessons learned from the statewide dissemination of an evidence-based practice?”. Through the presentation of separate quantitative and qualitative analyses from the statewide evaluation, and a presentation on the lessons learned, recommendations, and policy implications in Connecticut, participants in this symposium will gain a better understanding of how evidence-based practices such as MST can be disseminated statewide.

Is MST Effective for Connecticut’s Highest Risk Children and Youth? Quantitative Outcomes from a Statewide Evaluation of MST

Presenting: Jennifer Schroeder & Christian Connell

Introduction

MST is an intensive family and community-based intervention originally developed for youth with serious antisocial behaviors. Although much of the research conducted by the program developers has indicated that MST is effective in reducing recidivism, in terms of child and youth arrests, convictions, and incarcerations, independent reviews of MST effectiveness have shown that only about half of the studies demonstrated significant reductions in recidivism. However, in Connecticut, two prior studies of children and youth receiving MST services have shown positive outcomes for specific sites. One of the primary goals of the current evaluation was to investigate the effectiveness of MST for all youth receiving the service in Connecticut once the program was operating at its current capacity statewide.

Methodology

The design for the outcome component of this study is a quasi-experimental post-test only design. Existing demographic, treatment, and outcome data were mined and analyzed for youth who participated in MST during the study period from January 2003 to June 2006 ($N = 1,850$). Key variables in the analyses include: (1) demographic characteristics of MST participants including age, race, sex, income and diagnosis (partial sample); (2) descriptive data on treatment variables including length of treatment, family participation, intensity of treatment, treatment goals met, reason for discharge; and (3) data on treatment outcomes including whether the youth

was living at home, was in school, or was working at time of discharge, and (4) recidivism by type of offense.

The outcome component for this study includes outcomes for participating children and youth in terms of identified behavior change as measured by recidivism post-discharge and six key areas of functioning at discharge. Recidivism will be reported both by the type of offense and whether or not the offense was based on arrest or conviction for children and youth ages 11 to 18 years. State statute information will be used to classify recidivism into the following four categories: Families with Service Needs (FWSN), status offense or violation of court order or probation, misdemeanor, or felony.

Findings

Males comprised two-thirds (66%) of MST cases, and the average age of children and youth served was 15 years old at the time of intake. About one-third of children and youth were African American, another one-third were White (non-Hispanic), and just over one-quarter were Hispanic. About 40% of children and youth had diagnoses in two or more distinct diagnostic categories, meaning that children and youth served through DCF-funded MST providers exhibit a complex array of difficulties in functioning. Children and youth receiving MST services through CSSD usually fell into the High or Very High Risk categories, indicating that MST has been provided to the neediest population within Connecticut’s juvenile justice system. Historically, many of these children receiving MST would have been in residential placements away from their homes and communities. Median length of stay in the MST program was approximately 4.2 months from admission to discharge (as compared to 10 months for residential placement).

Eighty-three percent of children and youth had been arrested and 78% had been convicted of an offense prior to enrolling in MST. In general, charges and conviction rates were highest for misdemeanors, status violations, and FWSN, but 28% of children and youth had been charged with a felony and 12% had been convicted of one. When post-MST rates of recidivism were compared with pre-MST rates for children and youth in this sample, there was a decrease in the rate of recidivism for all types of offenses listed. Specifically, the rate of decrease in recidivism from pre- to post-MST in the current evaluation was 39% for any offense and 24% for felony or misdemeanor convictions.

Conclusions

The outcome recidivism rates found in this evaluation compare very favorably with previous estimates in the research literature of re-convictions among children and youth with a prior juvenile justice system involvement. For example, in Connecticut, a prior study of all children and youth receiving juvenile justice services in the state were convicted of misdemeanors or felonies at a rate of 46% at 18 months after discharge from services (CPEC, 2002). This rate is higher than the 37% conviction rate found in the current evaluation and was based on a sample of children and youth that included first-time offenders receiving less intensive services such as outreach and tracking as well as more serious offenders receiving more intensive services such as residential placement. When the authors compared the rate of conviction for only serious or high-risk offenders, the rate increased to 56%, indicating a recidivism rate that is 19% higher than that found in the current study for conviction of the same type of offenses at 18 months post-discharge for a similar

high-risk population. Given that the decision by CSSD to adopt MST statewide in 2003 was based in part on the results of this previous study by CPEC in 2002, it stands to reason that the decision has paid off in terms of reduced recidivism for this population of children and youth.

How is MST Working in Connecticut? Qualitative Outcomes from a Statewide Evaluation of MST

Presenting: Jennifer Schroeder

Introduction

Despite the recognized importance of large-scale implementation of evidence-based mental health practices (EBPs), few studies have examined the process of implementing such models on a statewide level. While there is an extensive and growing literature on “technology transfer” that looks at what it takes to move an EBP from the laboratory to the field, most of the previous work in this area has studied the experience of a single agency or organization in adapting a new treatment technology and focuses on the organizational variables that facilitate or impede implementation. There are few, if any, studies of this process with regard to EBPs in the children’s mental health field. The statewide adoption of Multisystemic Therapy (MST), by the Connecticut [the Court Support Services Division of the Judicial Branch (CSSD) and the Department of Children and Families (DCF)], provides a unique opportunity for such a study.

Method

The implementation component of this study draws on the review of implementation literature released by Fixsen, Naoom, Blase, Friedman & Wallace (2005). Fixsen et al. reviewed research on program implementation in multiple domains, identifying stages of implementation and core implementation components, ranging from exploration and adoption to innovation and sustainability.

These stages and factors were used as a framework for analyzing qualitative data drawn from 33 audio recorded and transcribed interviews and focus groups with 96 individuals including state agency leadership, juvenile court personnel, provider agency staff, and youth and families who received MST. Through these analyses, this study identifies how the relationship of the provider agency with the state has helped shape implementation at the provider level, how each provider agency’s own organizational dynamics influenced adoption of and fidelity to the MST program model, the obstacles to and supports for broad scale EBP dissemination by state agencies, and recommendations for future efforts.

In addition, outcomes of the Therapist Adherence Measure (TAM), and Supervisor Adherence Measure (SAM), which captures adherence to the MST model, were examined in order to better understand how model fidelity can potentially impact outcomes at the individual and provider level and further how adherence issues are related to implementation factors.

Findings

Results from qualitative analysis of interviews and focus groups indicated that the decision to adopt MST across the state resulted from both state agency and community provider readiness. State agencies were looking for an effective evidence-based practice to replace other less effective existing programs for delinquent youth. Providers who successfully adopted MST showed an immediate fit with the “culture” of evidence-based practice (i.e., short-term, goal oriented, and in this case community-based therapies). These findings map onto the first two stages of the Fixsen et al. model (Exploration and Adoption) such that Connecticut demonstrated initial exploration of effective programs and state and provider readiness to adopt MST.

When MST was initially disseminated throughout the state, communication with referral sources, judicial staff, community providers, and families was cited as the key factor to effective installation of MST, although this reportedly occurred less often than interview participants preferred. Factors related to successful implementation, both initially and when the program was operating at its fullest capacity statewide, included fidelity to the model, appropriateness of referrals, and family expectations for success and engagement. Additional quantitative data analyses indicated that measures of parent-rated therapist fidelity correlated with therapist-rated youth outcomes at discharge. However, therapist and supervisor turnover was cited as impeding successful implementation. In order to reduce turnover, therapists and supervisors reported that staff must be a “good match” for MST and provider agencies must provide both financial incentives and consistent feedback and encouragement. Provider agencies with high turnover reportedly offered less consistent support and financial “perks,” such as cell phones, laptops, and cars, which better enable therapists to respond to families in their communities. Quantitative data on length of employment confirmed therapist reports of high turnover at agencies that provided fewer supports to therapists. These findings help to inform recommendations for what Simpson and Fixsen et al. respectively identify as ongoing practice and program innovation and sustainability.

One of the key components of evidence-based practice is the ability to monitor quality assurance, to ensure that the practice or model is being implemented with fidelity and not deviating from its original design. Therapist fidelity to MST principles was assessed using the Therapist Adherence Measure (TAM; Henggeler & Bourduin, 1992). Across both state agency provider groups, average TAM ratings were consistently high (Average = 4.23), indicating that caregivers generally viewed therapists as quite adherent to the program. These results suggest that in Connecticut, MST is being implemented with high fidelity to the treatment model.

Throughout our many interviews, the people who are most familiar with MST (the probation staff, providers, and families), generally believe that it works. However, the efficacy of MST may have been oversold and it is not a “cure all.” But respondents reported it is a very effective treatment and the best tool our juvenile justice and behavioral health workers have at their disposal for high-risk children and youth.

We also consistently heard that this work is difficult. Burnout is high. Turnover is high. Providing MST is a difficult job for clinicians who have children or other non-work related obligations. The agencies that did the best retaining staff and receiving the highest job satisfaction ratings were those that recognized and addressed these challenges through morale building, providing incentives for their staff, and implementing policies (such as flex time) that helped compensate for high job stress.

Conclusion

The importance of this study cannot be underestimated. At the national level, Connecticut is one of the few states to adopt an EBP on a statewide basis, thus its experience can serve to inform federal policy-makers as well as other states interested in transporting such models into their systems of care for youth. At the state level, understanding of the MST experience can enhance future planning regarding EBP implementation as well as inform future resource allocation. At the local level, agencies can learn about the “real world” factors involved in implementing an EBP in a community-based setting.

Reference

Fixsen, D.L., Naoom, S.F., Blase, K.A., Friedman, R.M. & Wallace, F. (2005). *Implementation research: A synthesis of the literature* (FMHI Publication #231). Tampa, FL., University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network.

What are the Lessons Learned from the Statewide Dissemination of an Evidence-Based Practice? MST, Knowledge Transfer, and Policy in Connecticut

Presenting: Robert P. Franks

Introduction

The Connecticut Center for Effective Practice, a division of the Child Health and Development Institute, was formed in 2001 as an innovative partnership among key stakeholders in Connecticut. When the Center was first formed, the initial strategic priority was working closely with the Connecticut Department of Children and Families (DCF) and the Court Support Services Division of the Judicial Branch (CSSD) to conduct a statewide implementation of MST.

The MST teams that CCEP successfully established have been integrated into the state's juvenile justice service continuum, including early diversion, detention alternative, delinquency placement, and community aftercare. For the past three years, with funding from the Connecticut Health Foundation and DCF, CCEP has been working with state agencies to develop this evaluation to explore the implementation and outcomes of MST in the state of Connecticut.

The lessons learned from the evaluation, the recommendations generated from these findings, as well as the responses generated from the state and community to this evaluation will be discussed.

Methodology

In addition to integrating both quantitative and qualitative findings from the evaluation, the authors reviewed data released by the state on the costs of MST compared to residential treatment as well as the costs of MST outside of Connecticut to help put the findings into context for state leaders and community representatives. This information was then presented to leaders from DCF, CSSD, providers, and key youth advocacy groups in the state. A televised forum was also held at the state capital in Hartford to present evaluation results as well as to discuss the importance of effective implementation of evidence-based programs. Dean Fixsen, a nationally recognized expert in the implementation of evidence-based programs, served as the discussant for this forum, which was attended by legislators, state leaders, community representatives, provider agencies, and families.

Findings

Costs of MST vs. More Restrictive Treatments

For most families in Connecticut, MST provides five months of intensive, in-home service and costs approximately \$9,000 per family. The average cost of residential treatment for juvenile justice-involved children and youth, for example, costs about \$68,000 per year, exclusive of educational costs, over approximately 10 months of treatment. Thus, based on the results of this evaluation, MST not only helped reduce rates of recidivism in Connecticut while enabling children and youth to remain with their families in their communities, it also saved taxpayer dollars.

Lessons Learned

Improved Data Collection Processes. Completing a comprehensive, large-scale evaluation of services being provided to our children and youth is unnecessarily difficult and obstructive. We had to overcome the obstacles of having to explore four datasets who didn't "talk to each other" because they were developed independently. We also had to strategize ways of identifying children in different systems because they all had their own unique identifiers. This capacity building process will be discussed.

Equivalent Outcomes from Different Implementation Strategies. Results indicated that despite the separate and distinct implementation processes that occurred for each state agency, youth outcomes were equivalent in multiple domains. Implications for these separate and yet equally effective implementation processes will be discussed in terms of the key elements crucial for successful dissemination of evidence-based practices.

Workforce Development. There was a consensus in the qualitative interviews that, as a state, we must do better in our graduate programs and internship training to prepare our workforce for the kinds of jobs they will be performing in the "real world."

Importance of Structured Implementation and QA. Implementing a program like MST on a large scale takes a great deal of time, investment and attention to detail. The positive outcomes demonstrated in this evaluation have to be attributed to the highly structured implementation and QA mechanism that MST Services has established in combination with the dedicated staff at our state agencies and provider organizations. It is difficult to say if the program would have been as successful without this structure and support.

Success of MST Related to Combination of Factors. The authors found that rather than a perfectly planned process of implementing MST across the state, it was more of a "perfect storm." A combination of factors at the state policy level (KidCare legislation, legislative reviews, major reports), the agency level (champions of evidence-based practice, grant money, identified needs of children and youth, recognition that "business as usual" was not working), the collaborative level (creation of the Connecticut Center for Effective Practice), and the provider level (willingness to change, interest in evidence-based practice), led to the full-scale implementation of MST we see today.

Conclusions

Based on the findings from the evaluation and from discussions with state leaders and community representatives, the following recommendations were made and will be discussed further in the symposium.

- The State of Connecticut should continue to support in-home evidence-based practices, such as MST.
- Implementation of evidence-based practices and programs should include sufficient capacity building and "ramp up" amongst providers.
- Quality assurance and close monitoring of the fidelity of evidence-based practices to the program models is key to both successful implementation and outcomes.
- Ongoing workforce development is critical.
- Other key workforce development issues include attention to provider policies and practices that help retain staff and minimize high rates of turnover.
- State agencies should work together to streamline their data collection systems and make sure that data are more readily accessible and usable.
- Ongoing external evaluation of the outcomes of evidence-based practice is critical.
- Outcome data should be shared with stakeholders.
- Recidivism should be a clearly defined outcome at multiple levels.
- Family engagement is critical to any program's success.
- If additional resources are available, MST should also be considered for use with "medium to lower risk" children and youth.
- Participation in prosocial activities is an essential component

of positive outcomes in MST services and other juvenile justice interventions.

- Linkages to other services both during- and post-MST treatment should be considered and encouraged when appropriate.
- MST providers should seek out additional support through system supervisors, agency leadership, or community representatives to ensure that MST treatment is not only parent-focused but also actively involves the child and other systems such as the school.
- It is recommended that we set realistic goals and expectations for our programs and recognize that severe, chronic difficulties with children and youth who have had complex histories are difficult to treat and that incremental success should be supported and celebrated.
- Finally, the state of Connecticut should recognize that investments in programs and services with clear models, rigorous quality assurance, intensive supervision and systematic outcome data collection are well worth the investment.

Tuesday, March 3 » 1:30 pm

Special Session C Room 9	Topical discussion—Rapid Ethnography as Community-Based Participatory Research: Real Research for Real World Settings <i>Panel: Sharon Hodges, Kathleen Ferreira, Myra Alfreds & Knute Rotto</i>	Page 148
Session 36 Salon A-B	Symposium—Financing Strategies that Support Effective Systems of Care <i>Chair: Mary Armstrong</i> <i>Discussant: William Hudock</i> Implementing and Financing Evidence Based Practices in Systems of Care <i>Sheila Pires & James Wotring</i> Re-Directing “Deep End” Spending through Care Management Entities <i>Sheila Pires & Mary Armstrong</i> Financing Early Childhood Systems of Care <i>Beth Stroul & Ginny Wood</i>	Page 149
Session 37 Salon C	Identifying What Makes Systems of Care Successful <i>Vicki Effland & Janet McIntyre</i>	Page 151
	The Family Networks Initiative: A Collaboration Between a State Department of Family and Children’s Services and a Community-Based Children’s Mental Health Center <i>Borja Alvarez de Toledo</i>	Page 152
	Collaborating with Community-Based Organizations in Developing Systems of Care <i>Teresa Nesman, Linda Callejas & Debra Mowery</i>	Page 153
Session 38 Salon D	Symposium—System of Care Implementation: Findings from a National Survey <i>Chair: Krista Kutash</i> <i>Discussant: Robert M. Friedman</i> System of Care Implementation <i>Robert M. Friedman</i> Development of the System of Care Implementation Survey and County Selection and Respondent Identification and Recruitment Procedures <i>Roger Boothroyd</i> Overview of the System of Care Implementation Survey (SOCIS) Instrument and Descriptive Results from 225 Counties <i>Krista Kutash</i> Multilevel Confirmatory Factor Analysis of the SOCIS <i>Paul E. Greenbaum</i>	Page 154
Session 39 Salon G	Risk and Protective Factors in Native American Youth: A Preliminary Analysis <i>Barbara Friesen, Kris Gowen, Terry L. Cross, Kathleen Fox & Cori Matthew</i>	Page 158
	Tribal Youth Victimization and Delinquency: Analysis of Youth Risk Behavior Surveillance Data <i>Thomas Pavkov, Leah W. Travis, Kathleen Fox, Terry L. Cross & Kathryn Harding</i>	Page 159
Session 40 Salon H	Diffusion of Trauma-Informed Policies and Practices among Mental Health Agencies <i>Jeanne Rivard, Christine Walrath, John Gilford Jr. & Cynthia Hovor</i>	Page 160
	Evaluation of an Intervention for Adolescent Girls with Trauma Related Disorders <i>Meredith Elzy</i>	Page 161
	An Evaluation of Boys Town’s Family Preservation Program <i>Annette Griffith, Kristin Hurley, Stephanie Ingram & Claudine Cannezzaro</i>	Page 163

Session 41 Salon I	Building a Research Agenda: Implementation Research and Wraparound Literature <i>Rosalyn M. Bertram</i>	Page 164
	Evaluation of Wraparound Services within Erie County <i>Brian Pagkos, Heidi Milch & Mansoor Kazi</i>	Page 165
	A Rural, Non-Profit Model for Workforce Wraparound Readiness in Systems of Care <i>Ira Lourie, Jeff Folsom & Meghan Gallagher</i>	Page 167
Session 42 Salon J	System of Care Community Plans for, and Caregiver Perceptions of, Evidence-Based Treatments <i>Kurt Moore & Carolyn Lichtenstein</i>	Page 169
	Factors Associated with Perceptions of Need for Child and Adolescent Psychiatrists <i>Cathleen Lewandowski & Lara Kaye</i>	Page 170
	Understanding Community-Based Administrators' and Clinicians' Perspectives on Evidence-Based Treatment Implementation <i>Amy Herschell</i>	Page 171

Special Session C » 1:30 - 3:00 pm » Room 9

Topical discussion

Rapid Ethnography as Community-Based Participatory Research: Real Research for Real World Settings

Panel: Sharon Hodges, Kathleen Ferreira, Myra Alfreds & Knute Rotto

Community-based participatory research is described as a collaboration between researchers and participants, in which community stakeholders are engaged as members of the research team. The utilization of this type of research model within the field of mental health has broadened over the last few years, particularly in relation to community change efforts. Rapid ethnographic methods are often used by a research team to collect a large amount of data within a short period of time. This topical discussion will describe the integration of community-based participatory research and rapid ethnographic methods in the study of system-of-care communities. Leaders from two communities that participated in Case Studies of System Implementation will describe their experiences during the research project, including the challenges and benefits of this type of research and how they have utilized study results. The topical discussion will allow audience members to engage in discussion around this process.

Session 36 » 1:30 - 3:00 pm » Salon A-B

symposium

Financing Strategies that Support Effective Systems of Care

Chair: Mary Armstrong

Discussant: William Hudock

The purpose of this symposium is to present findings from this study in three areas that are critical to system of care development: financing to support systems of care for young children, financing for evidence based practices (EBPs), and financing to support a care management entity for children with serious mental health problems. The overall purpose of the study is to develop a better understanding of the critical financing structures and strategies that support effective systems of care for children and adolescents with behavioral health disorders and their families and to understand better how these financing strategies operate separately and collectively. Initial study tasks included convening a panel of financing experts, including state and county administrators, representatives of tribal organizations, providers, family members, and national financing consultants, to develop a list of critical financing strategies and study questions. The critical financing strategies were used to create the first study product, a Self Assessment and Planning Guide: Developing a Comprehensive Financing Plan, which addresses seven important areas to assist systems or sites (states, tribes, territories, regions, counties, cities, communities, or organizations) to develop strategic financing plans for building systems of care. The study team has completed all data collection activities, including 10 face-to-face visits to states and communities as well as three conference calls to an additional three sites with promising financing strategies and structures. Thirteen states and counties have participated in the study to date.

Implementing and Financing Evidence Based Practices in Systems of Care

Presenting: Sheila Pires & James Wotring

The Research and Training Center for Children's Mental Health (RTC) at the University of South Florida is conducting several five-year studies to identify critical implementation factors which support communities and states in their efforts to build effective systems of care to serve children and adolescents with or at risk of serious emotional disturbances and their families. One of these studies, Effective Financing Strategies for Systems of Care, examines financing strategies used by states, communities, and tribes to support the infrastructure, services, and supports that comprise systems of care. In addition to its five-year system of care implementation studies, the University of South Florida previously hosted the National Implementation Research Network (NIRN), which has examined a wide range of variables related to implementation of systems change. This presentation draws on the findings from both the study on Effective Financing Strategies for Systems of Care and the work of NIRN.

The five-year study on Effective Financing Strategies for Systems of Care was initiated in October 2004 and is conducted jointly by the RTC, the Human Service Collaborative of Washington, DC, the National Technical Assistance Center for Children's Mental Health at Georgetown University, and Family Support Systems, Inc. of Arizona. The purposes of the study are to: develop a better understanding of the critical financing structures and strategies to support systems of care; examine how these financing strategies operate separately and collectively; and promote policy change through dissemination of study findings and technical assistance to state and local policymakers and their partners. The study uses a participatory action research approach, involving a continuous dialogue with key users on study methods, findings, and products. The

study uses a multiple case study design; data collection and analysis includes a mix of qualitative and quantitative methods.

Among the major areas explored in the study is the financing of a broad array of services and supports, including evidence based and effective practices; this is a core tenet of systems of care. The study explored financing and incentives for states and communities to implement evidence based practices (EBPs), including financing to support the development, training and fidelity monitoring aspects of implementing EBPs. The study sites are implementing such EBPs as: Multi-Systemic Therapy, Multidimensional Treatment Foster Care, and Functional Family Therapy. The sites also are implementing effective practices such as high fidelity wraparound, mobile response and stabilization services, and parent partners. Among the strategies utilized by study sites, which will be discussed in the presentation, are: utilizing Medicaid to support EBPs, including establishing service definitions and billing codes; partnering across child-serving agencies to finance EBPs; and, utilizing savings from Medicaid managed care systems to implement EBPs. The presentation also will discuss how states and counties in the sample implemented EBPs in a variety of financing contexts, including fee-for-service and managed care arrangements.

Drawing on work from the NIRN, the presenters also will discuss the financial implications of building the infrastructure necessary to support the implementation of evidence based and promising practices within a system of care. One methodology to estimate the cost of building the complete infrastructure for an EBP will be shared. This includes the cost of training, coaching, fidelity monitoring, staff time to provide and participate in training and travel, and other infrastructure costs. Time will be allowed for participants to discuss the applicability of findings to their particular state and community contexts.

Re-Directing "Deep End" Spending through Care Management Entities

Presenting: Sheila Pires & Mary Armstrong

Among the major areas explored in the Effective Financing Strategies for Systems of Care study is how states and communities are re-directing spending away from restrictive, expensive services with limited outcome support to home and community based services. In most states and communities, there are very few new dollars to support home and community based service development for children with serious emotional disturbances and their families. Instead, states and communities are exploring ways of redirecting existing spending, particularly when dollars are buying high cost, poor outcome services. In addition, states and communities recognize that their high-utilizing populations of children with serious emotional and behavioral health challenges typically are involved in multiple systems, such as child welfare, juvenile justice, special education and behavioral health, with no one system accountable for quality and cost outcomes.

A number of states and communities in the study on Effective Financing Strategies for Systems of Care are financing Care Management Entities to serve as a locus of accountability for children with serious and complex issues who are involved in multiple systems. These Care Management Entities utilize a high fidelity wraparound approach to service planning, using child and family teams and, often, parent partners; they also ensure that families have a dedicated care coordinator who is accountable for working with children and families across systems. States and communities are financing Care Management Entities utilizing a variety of approaches, including use of Medicaid, case rates, blended funding from multiple systems, and performance-based contracts.

Tuesday – 1:30

The presentation will describe how states and communities are redirecting spending through Care Management Entities to expand home and community based services and supports, engage youth and families and other partners in high fidelity wraparound approaches, reduce use of restrictive services (such as residential treatment, group homes and inpatient hospitals), and improve clinical and functional outcomes.

Financing Early Childhood Systems of Care

Presenting: Beth Stroul & Ginny Wood

As mentioned above, the five-year study on Effective Financing Strategies for Systems of Care was initiated in October 2004 and is conducted jointly by the RTC, the Human Service Collaborative of Washington, DC, the National Technical Assistance Center for Children's Mental Health at Georgetown University, and Family Support Systems, Inc. of Arizona. Thirteen states and counties have participated in the study to date.

Project BLOOM is a study site that focuses on serving young children under the age of six with mental health challenges and their families within a system of care approach. Four Colorado communities have developed early childhood systems of care; many of the approaches have been adopted to promote the statewide development of systems of care for young children and their families.

Colorado uses multiple funding streams to finance early childhood mental health services. A funding matrix created by the National TA Center for Children's Mental Health was used to explore potential funding streams for early childhood mental health services. More than 50 funding sources were identified, and materials were developed for Project BLOOM and other Colorado communities (see Table 1). Training is conducted to assist communities to consider all potential sources of financing for early childhood mental health services.

Table 1
Service Funding Matrix

<i>State Funds</i>	<i>Other Sources</i>	<i>Federal Funds</i>
Developmental Disabilities	Lottery Funds	Entitlements:
Early Intervention	Tax Check Off	Medicaid
Exceptional Children's	Tobacco Funds	Title IV-E
Education Act	Gaming-Casino Tax	Social Security Income
Colorado Preschool	Divorce Fees	IDEA Part C and Part B sec.
Program	Fees on Speeding Tickets	611 and 619
Core Services (Child	Local Taxes	ECEA
Welfare)	Tax Credit	Block Grants:
Children's Health Plan	Mental Health Districts	Child Care Development
		Community Mental Health
		Substance Abuse Prevention and
		Treatment
		Social Services
		Maternal and Child Health
		Community Services
		Discretionary Grants
		Community Based Grants for
		the Prevention of Child Abuse
		and Neglect
		Family Violence Prevention and
		Services
		Head Start
		Juvenile Justice Formula Grants
		Indian Health Care
		Improvement Act
		Promoting Safe and Stable
		Families
		TANF
		Title I
		Title IV-B
		Title V Incentive Grants for
		Local Delinquency Prevention
		WIC
		Workforce Investment Act

The Project BLOOM systems of care utilize the funding from multiple agencies for early childhood mental health services, including:

- **Child Welfare** – Core services are provided by the child welfare system to keep children at home and avoid out-of-home placements and to facilitate reunification or another form of permanence. These include home based interventions, intensive family therapy, life skills, day treatment, sexual abuse treatment, special economic assistance, mental health services, substance abuse treatment services, aftercare services to prevent future out-of-home placement, and optional county designated services that prevent out-of-home placement or facilitate reunification or another form of permanence. State general fund dollars are given to counties to provide or purchase these core services.
- **Education/Special Education** – Colorado Preschool Program can fund a preschool slot for a child involved in a Project BLOOM system of care on an individual case basis. A representative from the education system is involved in the Early Childhood Council in each local community.
- **Mental Health** – Financing includes funds from the SAMHSA system of care grant and the mental health block grant to finance an array of early childhood mental health services.
- **Medicaid** – Finances clinical services.
- **Primary Care** – Some financing is contributed through the Health Care Program for Children with Special Needs, the Maternal and Child Health Block Grant. The funds are specifically designated for care coordination.
- **Developmental Disabilities** – State general fund and local dollars are used to provide family support and case management services.
- **TANF** – El Paso County uses TANF dollars for direct services such as child care, and some areas are receiving funding for mental health consultation.
- **Part C** – State general fund, federal grants funds, and local mill levy funds are used to purchase direct services, based on a list of 14 types of services including social and emotional interventions and enhanced service coordination, which can include wraparound.
- **Child Care** – Child Care Development Block Grant funds used for training and professional development related to early childhood mental health consultation.
- **Foundations** – Rose Foundation finances some early childhood mental health consultation, that the Colorado Health Foundation finances some professional development.

In addition to utilizing multiple funding streams used to support early childhood mental health services and supports, financing strategies were identified for components of systems of care, including:

- Developing the community and state-level infrastructure needed for early childhood systems of care,
- Implementing a wraparound approach to service delivery for young children and their families,
- Providing an array of services and supports, including evidence-based practices and trauma-focused therapies,
- Providing early childhood mental health consultation to primary care settings, early care and education providers, others, and
- Collaborative service coordination.

Financing strategies have included using Medicaid to finance services and supports, providing flexible funding and guidance for using flexible funds, utilizing state financing of early childhood mental health specialists at each children's mental health center, contracting with the statewide family organization for a range of family involvement activities, financing local family coordinators and family advocates, financing training in wraparound and evidence based practices, financing early childhood councils at the community level for planning and coordination, financing social-emotional screening, and others.

Session 37 » 1:30 - 2:00 pm » Salon C

Identifying What Makes Systems of Care Successful

Presenting: Vicki Effland & Janet McIntyre

Introduction

Since 2003, The Choices TA Center has completed annual assessments of Indiana communities implementing local systems of care. The Strengths-Based Site Assessment is based on the elements Sheila Pires (2002) identified as required structures in systems of care and on the necessary conditions articulated by Walker, Koroloff, & Schutte (2003) for supporting a collaborative individualized service planning process. The site assessment collects qualitative and quantitative data on several system of care elements, which address community representation (e.g., involvement by child-serving agencies, families, and other community members), system of care structure (e.g., project staff), fiscal issues, and outcomes.

Prior research using the Strengths-Based Site Assessment has focused on examining the extent to which systems of care develop over time. Using the stages of change (e.g., precontemplation, contemplation, preparation, action and maintenance) proposed by Prochaska, Norcross, & DiClemente (1994) and Rogers (2003) as the framework to assess system of care development over time, these studies revealed that the majority of sites moved into the preparation and action stages within three years of beginning to implement a local system of care. Relatively few communities attained the maintenance stage of system of care development, however. Thus, the purpose of the current study was to identify the characteristics of the most successful systems of care in Indiana, based on information available in the annual site assessments and on information obtained from interviews with system of care leaders.

Method

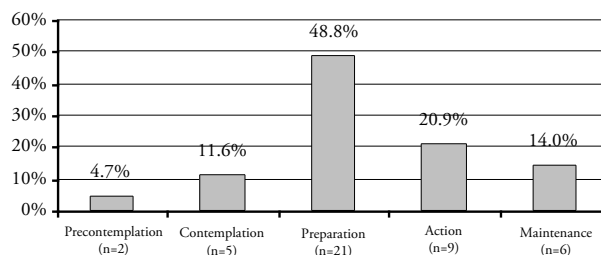
Between January and March, 2008, 43 communities were assessed using the Strengths-Based Site Assessment. Using a coding template based on stages of change (Prochaska, et al., 1994; Rogers, 2003), raters assigned each community to one of the five stages of change to indicate their level of system of care development. Detailed information from the site assessments was recorded in a spreadsheet and analyzed to identify those characteristics that made the communities in the maintenance stage of development successful. Semi-structured interviews were conducted with up to three system of care leaders (e.g., system of care project director, members of the systems' coordinating committee, family members) from the six communities rated as being in the maintenance stage. The interview asked respondents to identify the reasons for their success, primary challenges to system development and lessons learned in each of the primary areas of assessed in the site assessment (i.e., community representation, system of care structure, fiscal issues, and outcomes).

Results and Discussion

Figure 1 shows the percent of communities rated within each stage of system of care development. Within each of the areas assessed by the site assessment, characteristics of successful system of care communities emerged. First, systems of care in the Maintenance stage were more likely to have active involvement from representatives of all four child-serving agencies (i.e., mental health, child welfare, juvenile justice and education) than communities in the other stages of development. Additionally, 83% of systems of care in the Maintenance stage had active family involvement, compared to 14% of systems in the Preparation stage.

Second, in terms of system of care structure, the existence of a strong system of care (SOC) coordinator was identified as an essential characteristic of communities in the Maintenance stage. Specifically, SOC coordinators in the Maintenance stage had been in that role longer than coordinators in the Preparation stage (35.5 months and 20.3 months, respectively), had fewer responsibilities outside of the system of care, and had fully integrated the system of care values and principles into their position. Systems of care

Figure 1
Communities in Each Stage of Development



in the Maintenance stage also had more care coordinators and access to adequate supervision than systems in the other stages.

Third, developing a mechanism for sustainable funding is critical for all system of care communities and often one of the most difficult challenges facing Indiana's systems of care. All of the communities in the Maintenance stage receive public funding, compared to 66.7% of communities in the Preparation stage. Additionally, all of the communities in the Maintenance stage had a plan to blend funding and 83% had a sustainability plan compared to only 19% and 14%, respectively, of the communities in the Preparation stage.

Conclusion

Stroul and Manteuffel (2008) identified fourteen factors that system of care communities should incorporate into their sustainability planning (p. 229). Several of these factors (e.g., inclusion of key stakeholders, interagency partnerships, existence of ongoing leadership, presence of a champion with the power to focus energy and resources, and increased utilization of Medicaid for financing services) were also identified in this study as characteristics of communities in the Maintenance stage of system of care development. Additionally, Indiana provides all local systems of care access to coaching, training and support through the Choices TA Center, provides financial support to new systems of care, and continuously works to advocate for systems of care, create formal policies supportive of systems of care and engage additional political and policy leaders in the development of systems of care statewide. The lessons learned from the communities highlighted in this study can help other communities, especially those who do not have access to federal grant funds, achieve the Maintenance stage of system of care development and long-term sustainability.

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Session 37 » 2:00 - 2:30 pm » Salon C

The Family Networks Initiative:

A Collaboration Between a State Department of Family and Children's Services and a Community-Based Children's Mental Health Center

Presenting: Borja Alvarez de Toledo

Introduction

In 2004, the State of Massachusetts sought to reduce the number of children placed through its Department of Children and Families (DCF) (formerly the Department of Social Services) in residential treatment facilities and other types of congregate care, by launching the *Family Networks Initiative* across the state. Through this initiative, DCF would contract with local community-based providers to become the "Lead Agency" in each of its 29 service districts.

The role of the Lead Agency was to serve as the single point of entry into a local network of services for families and children referred to DCF. The Lead Agency would conduct a family-focused and family-informed assessment of a family's service needs, then contract with community organizations and institutions to provide needed services. In addition, the Lead Agency was charged with identifying and encouraging development of best practices in local communities.

The goal of the Family Networks Initiative was to reduce the need for out-of-home placements in residential treatment programs, group homes and treatment foster care by providing community-based services where feasible, and to shorten the length of time in such placements for those children who were unable to remain safely and securely at home (DSS Family Networks Legislative Briefing, April 2006).

Through a competitive application process in mid-2005, The Guidance Center, Inc. (GCI), was chosen as the Lead Agency for the DCF Area office serving Cambridge, Somerville and surrounding towns in the Greater Boston metropolitan area. It is the public-private collaboration between DCF and GCI in developing a system of care for children and families that is the focus of this presentation.

GCI, which was founded in the heyday of the child guidance movement in 1954, has since grown to provide a wide range of mental health, developmental and family support services to children from infancy to young adulthood. Because of its long history in the community and its overarching philosophy of family involvement all aspects of service delivery, GCI was an ideal choice to assume the newly-designed role of Lead Agency in the Family Networks Initiative.

Methodology

The Family Networks Initiative has two types of measurable goals. Process goals include (a) enhancing collaboration between the public and private human service sectors to expand available services to support and stabilize children in family and community settings; and, (b) increasing involvement of families and community providers in developing and reviewing a service plan for each child. According to the initiative, a Family Team meeting, intended to include family members, as well as community providers involved with the family, is to be held within 30 days of the initial referral and quarterly thereafter.

The other type of goal for the Family Networks Initiative encompasses the intended outcomes of this public-private collaboration: (a) reduction in the number of children placed out of home in residential treatment or other congregate care facilities; (b) reduction in the number of days

spent in residential treatment or other congregate care facilities for those children who must be placed in such care; (c) increase in the number of children who are stepped down to less restrictive community settings from residential treatment or other congregate care; and (d) increase in the number of children who are maintained in safe and stable homes in the community.

Measuring the success of the Family Networks Initiative over the past three years has involved collecting and analyzing administrative data on each of these process and outcome goals.

Findings

On both the process and outcome indicators, the public-private collaboration between DCF and GCI has demonstrated success over the three years from 2006 to 2008. Data from a recent review conducted by DCF shows a consistent pattern of developing community resources to support and stabilize referred families, particularly substance abuse services, and of identifying creative ways of expanding service availability such as increasing the use of services funded through public and private insurance.

In addition, the participation of family members in Family Team meetings has risen steadily to 81% in initial planning meetings and 84% at quarterly review meetings, while the participation of community providers tends to be greater at Family Team quarterly review meetings at 68% than initial planning meetings at 6%. The increased participation at review meetings for both families and community providers reflects the ongoing outreach by GCI's Family Networks case managers to ensure involvement of both.

Preliminary findings with regard to the outcome indicators show a 21% reduction in the use of residential treatment or other forms of congregate care from FY07 to FY08. For the 92 area children discharged from such facilities during 2008, 75% were stepped down to a less intensive form of care, while 12% were placed in a more restrictive setting, and 13% moved to another setting with a similar level of restrictiveness. Fifty-eight percent of those discharged returned to their families of origin, 29% were placed in a less intensive form of out-of-home placement, usually treatment foster care, and 13% had a variety of other outcomes. Of the children who returned home, 80% were still with their families 12 months after discharge.

Conclusion

The Massachusetts Family Networks initiative demonstrates how collaboration between a state agency (DCF) and a community-based organization (GCI) can play a significant role in establishing a system of care that benefits families and children, by increasing family and community involvement in insuring the safety and stabilization of children with emotional and behavioral challenges in the least restrictive, most normative settings possible. This presentation will identify the strategies used by one Lead Agency to implement the processes and achieve the outcomes prescribed by one state's public-private partnership.

Session 37 » 2:30 - 3:00 pm » Salon C

Collaborating with Community-Based Organizations in Developing Systems of Care

Presenting: Teresa Nesman, Linda Callejas & Debra Mowery

Introduction

The purpose of this presentation is to describe strategies for collaboration between community-based organizations and mainstream providers in developing culturally competent systems of care. Organizational and system characteristics will be presented, along with specific practices that have led to increased access, availability, and utilization of services by culturally/racially diverse populations.

Systems of care are challenged by multiple cultural, social, and structural factors that impact access to mental health services for culturally/racially diverse children and their families (Hernandez, Nesman, Isaacs, Callejas, & Mowery, 2006). Disparities in access can lead to reduced utilization, lack of improvement in clinical or functional outcomes, and an increased burden of care for economically and socially distressed communities and families (Hernandez, et al., 2006; Huang, 2002). Recommendations that have been made for improving access for diverse populations include addressing key organizational factors such as fragmentation, availability and cost of services, reducing stigma, mistrust and fear of treatment, and recognizing help-seeking styles, conceptualizations of illness, racism/discrimination, and language and communication patterns (Huang, 2002). A key factor for increasing access in systems of care is developing strong partnerships with community-based organizations (Callejas, Nesman, Hernandez, & Mowery, 2008). The research question for this study was: Are there observable and measurable field-based organizational practices within systems of care that are associated with improved access and utilization of mental health services by ethnically/racially diverse families?

Methodology

Sites were identified as “exemplary” by a panel of researchers, practitioners, and family advocates who work in the areas of cultural competence and disparities in mental health, based on an agreed upon set of criteria. Nominated sites participated in an initial semi-structured screening interview and a document review. Twelve sites were selected; seven for site visits and five for telephone interviews. A total of 151 interviews were conducted with a variety of stakeholders, including administrators, direct service personnel, funders, evaluators, and/or family representatives.

Two versions of semi-structured interview protocols (one for organizational personnel and one for family members receiving services) were developed, piloted, and revised before use. Multidisciplinary and multilingual interview teams conducted all interviews, focusing on strategies that have increased service access, availability, and utilization for African American, Asian/Pacific Islander, Latino, and Native American populations.

Interview responses from each site were coded using ATLAS.ti version 5.2 qualitative analysis software (Scientific Software Development, 2006). Coded concepts were placed into code “families” or larger categories that corresponded to specific components of the conceptual model of organizational cultural competence developed for the Research and Training Center for Children’s Mental Health Study 5 (Hernandez, Nesman, Isaacs, Callejas, & Mowery, 2006). Each strategy was defined using evidence derived from all interviews and supported by examples from each site.

Findings

The identified strategies were divided into direct service level and organizational level functions. *Direct service strategies* were those implemented by personnel such as outreach workers, case managers, and therapists through direct interaction with children and families. Some of these strategies included complex issues of simplified intake process, cultural and spiritual resources, and ethnic match, and more basic issues of transportation, childcare, and system navigation.

Organizational infrastructure strategies were implemented or developed at an administrative level within organizations or systems, did not involve direct interaction with children and families, and/or were associated with funding and policymaking. The organizational infrastructure strategies included issues of staff training and development, strategic hiring decisions, financial flexibility, cultural competence training, and linkages to and incorporation of informal supports and natural resources.

Findings of this study highlighted the different perspectives, challenges, and roles for community-based organizations and mainstream service providers that are collaborating on the development of culturally competent service systems. For example, a strategy used by one organization serving an African American community involved increasing awareness of the strengths and service needs of its community through collaboration on grants with mainstream providers and engaging local church leaders in reducing stigma related to mental health. A community-based organization serving primarily Native Americans on the West Coast collaborated with both mainstream and Native agencies to accept referrals and develop MOUs to co-locate their staff at partner agencies. An agency located in the Pacific Northwest increased the cultural competence of the system of care working with Asian/Pacific Islanders by collaborating with the county mental health provider to develop procedures for reimbursement for cultural consultation and certified linguistic/cultural interpreters. And, a Latino serving organization in the Southwest expanded its intra-organizational service array by developing for-profit businesses to bring in unrestricted dollars and increase community resources. In each case, the community-based organization served a slightly different role, sometimes as initiator of collaborative relationships and advocate of cultural competency, and in other cases as new partners in collaborative development of culturally competent systems.

Conclusion

The findings emphasized the overall lack of appropriate services for families in culturally/racially diverse communities and the need to either advocate for incorporation of new services within the system of care or seek funding to develop services within a specific community-based organization. In every site studied, the identified strategies were carried out in combination with other strategies and their manner of implementation was adapted to their community and service system contexts. Such adaptations required responsiveness, including in-depth knowledge of the community, ongoing assessment of needs and resources, and deliberate linkages between formal and informal, community-based and mainstream services and supports. Although the effectiveness of these strategies has reached a level of acceptance by the organizations and communities served, this has not been measured empirically. Additional research is recommended to further operationalize and measure the effectiveness of these strategies as well as determine which strategies are linked to improved mental health outcomes in these populations.

Tuesday – 1:30

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Session 38 » 1:30 - 3:00 pm » Salon D symposium

System of Care Implementation: Findings from a National Survey

Chair: Krista Kutash

Discussant: Robert M. Friedman

The Systems of Care concept has reformed public policy in how mental health service delivery systems for youth with severe emotional disturbances and their families should be organized and delivered. While the System of Care approach has been implemented nationally with all states having received federal support through the Comprehensive Community Mental Health Services for Children and Their Families Program, little is known about the level of implementation on a national basis. This symposium examines the national level of implementation of the core concepts contained within the System of Care in 225 counties randomly selected and stratified by population size and poverty level. Specifically, the presentations provide a rationale for the study, describe the development of the System of Care Implementation Survey (SOCIS) instrument developed specifically for the study, and provide an overview of the research design, and initial descriptive results and multilevel analyses results. Challenges inherent to this type of research design and areas for future research will also be discussed.

System of Care Implementation

Presenting: Robert M. Friedman

Contributing: Paul E. Greenbaum, Wei Wang, Krista Kutash, & Roger Boothroyd

For almost 25 years now, a major policy emphasis in children's mental health at the federal level and within most states has been the development of community-based systems of care. There have been many meetings and conferences about this, training and technical assistance material has been provided, and written material has been prepared, and a federal grant program, the Children's Mental Health Initiative (CMHI) has now provided funding to over 100 grantees for the development of such systems of care.

The present study addresses two important challenges in this effort. The first is determining the present status of systems of care in communities across the country—until this time there has been no national study that offers data from a random and representative sample of communities on the status of systems of care. The second challenge is to develop a conceptual model to help guide the effective implementation of systems of care, and the research.

Such information provides an important benchmark for the children's mental health field, much as surveillance data does for any public health field. It also offers practical information on the aspects of system of care implementation that appear to require the most work. Unless such information is available, efforts to improve system of care implementation and to assess the progress are left without adequate data either for evaluative purposes or for guiding the effort.

The Research and Training Center for Children's Mental Health (RTC) at the University of South Florida developed a conceptual model of 14 factors that it believes to be related to effective implementation of systems of care (Friedman, 2007). This model of factors was developed based on input from key stakeholders from different perspectives, review of research in children's mental health and related fields, and the experience of RTC staff in working with communities around the country. Each factor in this model was then operationalized via a set of survey questions which, taken together, form the SOC-IS – the System of Care Implementation Survey. The development of this survey instrument is described in other papers in this session.

The RTC made the decision that the unit of analysis for studying the status of systems of care should be the counties. It was decided to focus on counties rather than states because there may be considerable variability within states on the status of systems of care. Also, since systems of care are intended to be community-based, the RTC believed that it was essential to identify a unit of analysis that was a close representation of communities.

Having made the decision to focus on counties as the unit of analysis, the RTC then decided to select a stratified random sample of approximately 10% of the counties in the United States. The decision was further made to use population size as one factor in the stratification because of the enormous differences between large counties like Cook County, Illinois, and Los Angeles County, California, and many of the small, rural counties in our country. It was further decided to divide the counties into those who were above or below the median for socioeconomic status, and to stratify based on that factor as well.

This effort to secure data on the status of a complex service delivery system in 225 counties was a major undertaking. There are very few precedents for it and the RTC hopes that the methodological approach that was taken will be of value not only in children's mental health but in other related fields as well.

The following papers provide detail on the instrument development, the data collection, and preliminary results. They demonstrate that this very challenging task was in fact doable. Now it is hoped that the findings will be of practical use in guiding efforts at a federal level and within states to improve systems of care. It is also hoped that the value of the data and the methodological lessons learned will lead to recurring efforts to collect such data, and to the continuous improvement of the methodology.

Reference

Friedman, R. M. (2007). *Conceptualization and measurement of systems of care: Implications for maximizing the effectiveness of systems of care*. Presentation at the 20th Annual Research Conference—A system of care for children's mental health: Expanding the research base. Tampa, FL.

Development of the System of Care Implementation Survey and County Selection and Respondent Identification and Recruitment Procedures

Presenting: Roger Boothroyd

Contributing: Paul E. Greenbaum, Krista Kutash, & Robert M. Friedman

This summary describes the development and pilot-testing of the System of Care Implementation Survey (SOCIS) and the procedures used to select participating counties and the strategies employed to recruit respondents from five stakeholder groups.

Questionnaire Development

SOCIS development involved a multistage process. A comprehensive literature review was conducted to identify the domains associated with successful implementation of children's systems of care. Teams of "experts," including parents, drafted domain definitions and generated statements important for assessing each domain. Statements were edited for redundancy and structured in a common format to ease administration. Domain definitions and survey statements were reviewed by a national panel, also including parents, who rated the importance of each statement and identified existing gaps. Domain definitions and statements were modified based on reviewers' comments and resulted in the first version of the SOCIS.

Piloting the SOCIS Survey and Data Collection Procedures

The SOCIS was pilot-tested to assess the (1) adequacy of the protocol, (2) feasibility of data collection procedures, and (3) time required to obtain completed responses. Seven counties were randomly selected based on population size. Respondents included about 50 individuals from each target audience (parents, special education directors, county mental health directors, MH provider administrators and direct service providers). Some respondents participated in a cognitive interview during which they discussed their reactions to and understanding of each statement.

To recruit respondents, emails were sent to the state directors of children's mental health services informing them about the study, specifying the county(ies) selected in their state, and asking for a contact in each county to help identify respondents. Once identified, study staff called county contacts to identify potential respondents.

Despite initial contacts, connecting proved time consuming. Multiple calls and emails were required to secure responses. When connections were made, county contacts were helpful in identifying potential SOCIS respondents. Results from the pilot-test indicated on average, five calls

over a seven day period were necessary to obtain a completed survey. To decrease this time, the use of web searches was pilot-tested. These efforts proved useful in identifying respondents from the service providers and special education stakeholder groups and were incorporated into data collection procedures.

Another issue was identifying appropriate informants to complete the SOCIS. This challenge was due in part to different organizational structures associated with various child serving systems. For example, in smaller counties, providers, school districts, and family organizations were more likely regionally-based as opposed to county-based. Finding the appropriate regional entities was challenging. Additionally, respondents expressed difficulty restricting responses to a specific county in contrast to the region served. In larger counties, multiple child serving systems (e.g., multiple school districts within a county) existed, creating challenges identifying appropriate respondents. In this situation, respondents expressed difficulty broadening their perspectives to the entire county as opposed to the area served.

Multiple strategies were available and piloted for obtaining SOCIS responses; these include telephone interviews, email attachments, faxed copies, and mailing hard copies with stamped return envelope. Respondents identified several issues with the SOCIS. Some felt it was too long, others experienced difficulty responding to statements in some survey sections, others expressed a desire to have the survey on-line. In response to these comments, the survey was shortened; respondents were allowed to skip sections they could not answer, and a web-based survey was developed.

A psychometric analysis was performed on the pilot responses and a qualitative analysis was conducted on responses from the cognitive interviewing. Based on these analyses, the SOCIS was reduced to 77 statements (not including demographic information). The final version of the SOCIS was translated into Spanish and a web-based version was developed.

Selection of a National Sample of Counties

A probability sample of 225 counties was used to assess the level of implementation of systems of care implementation. Data on county population size and poverty rates obtained from the National Association of Counties on all 3,083 U.S. counties (National Association of Counties, 2008), were categorized into 14 strata (7 population sizes x 2 poverty levels). A disproportionate stratified probability sample was selected from each stratum. Smaller counties were purposely under-represented to insure the sample included counties serving most of the nation's children. The sample included counties in 46 states and the District of Columbia (Not sampled: Alaska, Iowa, Montana, Nevada, and South Dakota).

Selection and Recruitment of Respondents within Counties

In each county we attempted to identify 3-10 key informants with knowledge of the local children's mental health system to complete the SOCIS. The five stakeholder groups included:

1. County children's mental health directors
2. Directors of special education
3. Direct service administrators and service providers
4. Family advocates
5. Parents

The goal was to obtain 1,959 completed surveys across the nation. Multi-facet identification, recruitment, and survey administration strategies were used. Trained staff collected survey responses. Each person received intensive training and was assigned a county "caseload" within the same state. Given the variability that exists across states in how

children's mental health and school systems are organized, staff were encouraged to work in one state at a time to become familiar with the manner in which the systems were organized. Staff participated in weekly meetings during which issues such as successful recruitment strategies and problems encountered were discussed.

Staff initiated searches to identify key informants in each stakeholder group using web-based searches and resources. Once potential respondents' names were identified, staff contacted them by telephone or email. When contacted, the study purpose was explained and they were asked to complete the SOCIS. If an individual agreed, they received multiple options for completing the survey (i.e., telephone, email, mail, and web-based). Most selected the web-based option. Individuals selecting this option received an email invitation along the link to the web-based SOCIS survey. Weekly reminders were emailed to individuals who agreed but had not completed the survey. If a prospective respondent did not complete the SOCIS within five weeks, their name was removed and attempts were made to recruit another person from that stakeholder group. Respondents also assisted in identifying other potential respondents.

When data collection was initiated in a state, an email was sent to the Director of Children's Mental Health Services listing the counties included in that state and requesting assistance in identifying a contact in each county to assist in identifying other survey respondents.

Prior to initiating data collection, study procedures, scripts, and protocols were reviewed and approved by the University of South Florida's IRB to ensure the rights of study participants were protected. Staff completed IRB and HIPAA training and received training on study goals and strategies for recruiting respondents.

Reference

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Overview of the System of Care Implementation Survey (SOCIS) Instrument and Descriptive Results from 225 Counties

Presenting: Krista Kutash

Contributing: Paul E. Greenbaum, Wei Wang, Roger Boothroyd & Robert M. Friedman

This section provides an overview of the System of Care Implementation Survey (SOCIS) instrument along with the initial results from 225 counties. Specifically, the subscales contained within the SOCIS will be described and the initial results from participating counties will be presented.

The SOCIS contains 76 Likert response items with 4 to 5 items for each of the 15 subscales. Fourteen subscales measure specific topics within system of care implementation while the remaining subscale measures perceived general system performance. The topics measured by the SOCIS along with their definitions can be found in Table 1.

A total of 910 key informants completed the SOCIS and included mental health administrators or direct care providers ($n = 307$, 34%), special education staff ($n = 243$, 27%), family members and advocates ($n = 72$, 8%), and other service-related personnel ($n = 288$, 31%). For 146 counties (65%), three or more informants provided information.

Initial analyses assessed the psychometric properties of the survey instrument. Results based on coefficient alpha, which ranged from .69

Table 1
Factor Definitions

Factor	Definition
1. Family Choice and Voice	Family and youth perspectives are actively sought and given high priority during all planning, implementation, and evaluation of the service system.
2. Individualized, Comprehensive and Culturally Competent Treatment	A range of services that is available to support the development of individualized, culturally competent, and comprehensive treatment plans that assist the child and the entire family. Individualized treatment is when the services provided are based on the specific needs and strengths of individual children and their families. Comprehensive treatment addresses functioning across the full array of life domains. Culturally competent treatment addresses the specific cultural/racial/language characteristics of the family, community, and service providers that impact treatment plan effectiveness.
3. Outreach and Access to Care	Outreach and service access are procedures (e.g., home visits, mental health workers in the schools) that facilitate obtaining care for all individuals in the identified population of concern.
4. Transformational Leadership	Transformational leaders are individuals who, articulate a long-term vision that inspires others, challenge assumptions and take risks, and listen to the concerns and needs of others.
5. Theory of Change	A Theory of Change is the expressed beliefs and assumptions for how to serve child and adolescent populations and reach identified goals.
6. Implementation Plan	An implementation plan identifies procedures and strategies to achieve goals and objectives at program and system levels and includes projected timelines and expected outcomes.
7. Local Population of Concern	The intended beneficiaries of the service system (i.e., the local population of concern) should be clearly described. Specific information should include the number of children and adolescents who are eligible for services, their ages, diagnostic profiles, demographics including cultural/racial/language diversity, location in the county, services histories and any special needs of groups in the population.
8. Interagency and Cross-Sector Collaboration	A formal process concerned with facilitating collaboration among the various child-serving sectors (e.g., mental health, education, child welfare, juvenile justice). This process usually includes an Interagency Committee, which has designated participants who represent the various agencies and have regularly scheduled meetings.
9. Values and Principles	Values and Principles refer to an explicit statement of core values and principles that guide system development and evaluation. These values and principles have been adopted through an inclusive, participatory process. For example, core values may include: Child-centered and family-driven: The needs of the child and family dictate the services provided. Community-based services: Management and decision-making responsibility reside at the community level. Culturally competent: Agencies, programs, and services are responsive to the cultural, racial, and language diversity
10. Comprehensive Financing Plan	A comprehensive financing plan is consistent with the goals of the system, identifies expenditures across major child-serving sectors, utilizes varied sources of funding, promotes fiscal flexibility, maximizes federal entitlements, and re-directs spending from restrictive placements to home- and community-based services.
11. Skilled Provider Network	A skilled provider network represents an assessment of the group of service providers that populate a particular system. They should be diverse in background, culturally competent, effective in providing services, behave consistent with the values and principles promoted by the system, and have sufficient capacity to provide family choice.
12. Performance Measurement System	The ongoing monitoring of program/system accomplishments, particularly progress towards pre-established goals. Performance measurement systems involve regularly collected data on the level and type of program/system activities (process), the direct products and services delivered by the programs (outputs), and the results of these activities (outcomes).
13. Provider Accountability	Funding for providers is tied to their performance so that incentives have been created for high quality and family-responsive outcomes.
14. Management and Governance	Management and Governance refers to decision-making individuals and groups that are responsible for maintaining the system's values, principles, goals, and strategies. They use data and stakeholder input to manage and continuously strengthen and improve the system.

(Skilled Provider Network) to .94 (Transformational Leadership) and standard confirmatory factor analysis (CFA) suggested that all 14 implementation factors were measured reliably and were significantly correlated with each other as predicted by the implementation model. Intercorrelations among the factors formed a second-order "general" factor with factor loadings ranging from .48 (Local Population of Concern) to .86 (Theory of Change, Skilled Provider Network, and Management and Governance).

The factor with the lowest average was Skilled Provider Network (mean = 2.39) and the factor with the highest overall mean was Values and Principles with a mean of 4.02, see Table 2 for the subscale means by respondent type.

Differences among respondent types were found in preliminary analyses of the subscale or factor means. Perhaps not surprisingly, mental health respondents rated all of the 14 implementation factors and the Overall General System Performance factor higher than family members/advocates and respondents

Table 2
Subscale/Factor Means by Respondent Type

Factor*	Respondent Type				
	All (n=910)	Mental Health (n=307)	Education (n=243)	Family (n=72)	Other (n=288)
How knowledgeable are you about your local children's mental health services system?	4.32	4.64	3.91	4.45	4.33
To what extent do you believe your local children's mental health services system is a System of Care	3.22	3.47	2.96	3.13	3.20
1. Family Choice and Voice	3.48	3.71	3.16	3.46	3.49
2. Individualized, Comprehensive and Culturally Competent Treatment	3.80	3.79	3.64	3.43	3.76
3. Outreach and Access to Care	3.02	3.26	2.87	2.96	2.98
4. Transformational Leadership	3.76	3.91	3.59	3.51	3.76
5. Theory of Change	3.70	3.76	3.59	3.31	3.75
6. Implementation Plan	3.53	3.67	3.31	3.22	3.43
7. Local Population of Concern	3.56	3.81	3.11	3.61	3.54
8. Interagency and Cross-Sector Collaboration	3.01	3.15	2.81	2.93	3.05
9. Values and Principles	4.02	4.16	4.27	3.47	3.89
10. Comprehensive Financing Plan	3.09	3.25	2.82	2.80	3.11
11. Skilled Provider Network	2.39	2.46	2.17	2.27	2.46
12. Performance Measurement System	3.22	3.26	3.16	3.09	3.22
13. Provider Accountability	2.98	3.08	2.58	2.81	3.06
14. Management and Governance	3.37	3.48	3.23	3.19	3.35
15. General System Performance	3.09	3.41	2.67	3.10	3.06

* All factors are on a 5 point scale with 5 being best.

from either education or other service-related sectors. Another consistent pattern is the lowest ratings came from education sector respondents (except for the Values and Principles subscale).

This presentation will conclude with an outline of future analyses planned for the data as well as policy and service system implications.

Multilevel Confirmatory Factor Analysis of the SOCIS

Presenting: Paul E. Greenbaum

Contributing: Wei Wang, Krista Kutash, Roger Boothroyd & Robert M. Friedman

Introduction

No data currently exist on the overall national status of community-based systems of care and on factors believed to be associated with system of care implementation. As part of a study designed to assess Systems of Care nationally, a survey instrument, the Systems of Care Implementation Survey, (SOCIS, Greenbaum, Friedman, Kutash & Boothroyd, 2007), was developed to measure each of 14 factors identified with Systems of Care (SOC) implementation. The purpose of the present study was to test a multilevel measurement model for each SOC factor using a probability sample of U.S. counties and diverse community informants. By establishing a measurement model for each factor, the ability to measure these factors at the community level, and ultimately target and provide meaningful assistance to communities in the development and implementation of their systems of care will be greatly improved. Specific research questions addressed include the following:

1. Do the items used to measure each factor fit a unidimensional factor structure?
2. Do the selected items load significantly (i.e., greater than zero) on the designated factor?

3. Is there significant community-level (level-2) variance for each factor?
4. Are the item loadings the same for individuals (level-1) and communities (level-2)?

Methodology

This study administered the SOCIS survey nationally to a disproportionate stratified probability sample of public mental health systems from 225 randomly selected counties. Within each county, multiple informants from different service sectors and family members/advocates of children being served responded to multiple questionnaire items about each implementation factor for their community's SOC. Nine-hundred and ten informants, including family members and advocates ($n = 72$), child-serving professionals from mental health ($n = 307$), education ($n = 243$), and other agencies (e.g., child welfare, juvenile justice, $n = 288$) answered the survey.

Using information from multiple informants, rather than from a single informant such as the director of a mental health agency, was viewed as a way of providing a more comprehensive assessment of SOC implementation. Family members/advocates and individuals from different service sectors may share common information about their SOC but they may also have unique information, based on their particular organizational experiences. In our data collection design, individuals were linked to specific counties, so that SOC implementation could be examined using a multilevel framework, which allows for simultaneous psychometric analysis of the SOC implementation factors at the individual informant and community or county levels.

The multilevel approach uses a two-level model to partition and analyze simultaneously the covariance matrix of the observed data into separate covariance matrices at the within- and between-group levels (i.e., level-1 and level-2, respectively). Analysis at each level takes into account the nonindependence of the observations while also allowing for an examination of the underlying factor structure at both levels. Because our primary interest was in implementation at level-2, the county level, we used the multilevel approach to conduct multilevel confirmatory factor analyses (MCFA, Muthén & Muthén, 1998-2007) on the 14 implementation factors.

Findings

Fit of the models. All unidimensional measurement models for the 14 factors were adequate fits to the data. Model fit indices were above the recommended cutoff values of .95 for the CFI and TLI and below the .08 cutoff value for the RMSEA. CFI's for the 14 factors averaged .987 and ranged from .958 to 1.000; for the TLI, the average value was .977 and ranged from .942 to 1.001; and for the RMSEA, the average value was .034 and ranged from .000 to .056.

Loadings. All item loadings for all factors were statistically significant at the within- and between-levels, t -values > 2.00 , p -values $< .05$.

Variances. An important test of the between-county model is whether the level-2 variance was sufficiently large (i.e., significantly different from zero) so that a two-level analysis is warranted. The level-2 between-county variance for each factor was tested for significance using the critical ratio of the estimated variance divided by its standard error. Using this criterion, 6 of the 14 factors had a significant level-2 variance indicating that these factors had sufficient variability at the county level to warrant further analyses of mean differences between counties. The six factors were: (1) Family Choice & Voice, (2) Outreach & Access to Care, (3) Transformational Leadership, (4) Local Population of Concern, (5) Interagency & Cross-Sector Collaboration, and (6) Comprehensive Financing Plan.

Equality of loadings across levels. For the six factors that had significant level-2 variance, nested model tests of equality of the loadings indicated no significant differences between loadings at both levels.

Conclusion

The SOCIS questionnaire measures 14 unidimensional factors associated with SOC implementation. All of the indicator items load significantly on their designated factors and those with significant level-2 variance have equal loadings across levels. Among the 14 factors, 6 have sufficient between-county level variance to warrant further multilevel regression analyses. Future research should determine if the nonsignificant level-2 variances are a function of either individual- or community-level variability.

Session 39 » 1:30 - 2:30 pm » Salon G

Risk and Protective Factors in Native American Youth: A Preliminary Analysis

Presenting: Barbara Friesen, Kris Gowen, Kathleen Fox & Cori Matthew

Introduction

This presentation highlights preliminary findings from analysis of a self-administered assessment tool (NAYA Assessment Tool; NAT) developed with/for Native American youth. This work is part of a larger collaborative project designed to assist community- and culturally-based programs to assess the effectiveness of their programs and activities. The NAYA Youth and Family Center, the National Indian Child Welfare Organization, and Portland State University are using a participatory research process to identify outcomes, document program activities, measure baseline indicators for individual youth and track youth progress over time.¹

The NAT is designed to be used by Native American Youth who are NAYA participants and their case managers to develop plans within the Relational World View model² comprised of four quadrants: mind, body, spirit, and context. Indicators of success derived from a broad constituency of Native American elders, agency board members, staff, youth, families, and community partners served as the foundation for the development of the NAT, which includes both risk and protective factors. This analysis focuses on the relationship between measures of resilience, perceived discrimination, and hope; and measures of drug use, alcohol use, and the youth's emotional state.

Resilience has been defined in many different ways. A common definition of resilience is a person's ability to overcome difficult challenges despite adverse experiences. However, other definitions of resilience encompass not only an individual's capacity to navigate through tough situations, but also the availability of resources in the individual's family, community, and culture to provide support.^{4, 5}

Studies of youth outcomes suggest that hope is associated with positive outcomes such as lower substance use⁶ and school success.⁷

In contrast, perceived discrimination among AI/AN youth has been found to be associated with increased reports of depressive symptoms⁸ and a higher risk of suicidal behavior.^{9, 10} There is evidence that involvement in traditional culture may act as a buffer of discrimination's effects.¹¹

The purpose of this paper is to examine the inter-relationships among perceived discrimination, resilience, and hope in a sample of American Indian youth based in the Portland metropolitan area. In addition, we will examine the relationship between these phenomena and health risk behaviors, most notably alcohol and drug use, and depression and suicidality.

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Methodology

The NAT is administered online using an internet-based survey platform. As part of a pilot project, 51 youth who participate in NAYA services completed the online form in a computer lab at their community center. Their case manager was available in case they had any questions.

Both youth and parental assent/consent were received for this project. Human Subjects approval was obtained through Portland State University.

The independent variables in this study are the Ungar Resilience Scale, a perceived discrimination scale adapted from LaFromboise¹², and the Children's Hope Scale¹³. Dependent variables included: (1) one item asking youth if they had ever used drugs, (2) two items related to alcohol use: asking youth if they ever drank alcohol and drank alcohol in past 30 days, (3) one item asking youth how "calm and peaceful" they felt over the past 30 days, and (4) an abbreviated version of the CES-D, a scale that measures depression.¹⁴

Findings

Preliminary data on this sample ($N = 51$) were used to tabulate these results. It is anticipated that by the time of the presentation, we will have a sample size of 120.

Only two persons stated they had considered attempting suicide in the past 12 months, so at this point there is insufficient data for analysis regarding this variable.

Among the independent variables, there was no significant correlation between perceived discrimination and either hope or resilience. Resilience and hope were positively correlated ($r = .31, p < .05$).

Drug use was associated positively with perceived discrimination ($F(41) = 4.00, p < .05$), and negatively with hope ($F(46) = 7.03, p < .01$) and resilience at a trend level ($F = 2.88(46), p < .10$). Alcohol use in the past 30 days was associated with lower levels of hope ($F(22) = 6.11, p < .05$). Higher resilience was associated with higher levels of feeling calm and peaceful ($r = .34, p < .05$) and lower levels of depression ($r = -.46, p < .01$).

Relationships between dependent variables and positive cultural identity will also be explored in future analyses.

Conclusions

Results indicate that resilience, as measured through a combination of individual capacity and external resources, is significantly associated with positive mental health and lower levels of drug use in a sample of urban Native American youth. Similarly, hope was related to lower levels of drug and alcohol use. Perceived discrimination was associated with a higher likelihood of drug use. Our continued research will explore the particular factors within resilience that best predict positive outcomes in Native American youth.

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Session 39 » 2:30 - 3:00 pm » Salon G

Tribal Youth Victimization and Delinquency: Analysis of Youth Risk Behavior Surveillance Data

Presenting: Thomas Pavkov, Leah W. Travis, Kathleen Fox & Kathryn Harding

Introduction

Statistics from the US Department of Justice show that the rate of violent victimization among American Indian/Alaska Native youth is almost double that of all races (USDOJ, 2004). Native youth are also more likely than youth of other races to be victims of abuse and neglect (Cross, Earle & Simmons, 2000). The number of AI/AN youth in the custody of the Federal Bureau of prisons increased by 50 percent between 1994 and 2000 (Andrews, 2000) and now approximately 74 percent of the youth in custody of the Federal Bureau of Prisons are AI/AN (Federal Bureau of Prisons, 2008).

Insufficient information is available to explain the high rates of crime and incarceration of AI/AN youth. Anecdotal news from Indian Country implicates maltreatment and other aspects of life in tribal communities. Without reliable knowledge, attempts at mobilizing advocacy efforts have gone without funding and have failed to gain traction. Research is needed to raise awareness of the issues and to justify the need for funding to address the issues. The Office of Juvenile Justice and Delinquency Programs (OJJDP) has funded the Tribal Youth Victimization and Juvenile Delinquency Project to conduct research investigating these interlocking issues as a partnership among three separate agencies serving disparate constituencies. These are Prevent Child Abuse America (PCAA), the National Indian Child Welfare Association, and Purdue University Calumet.

The goal of the project is twofold: to complete analysis on existing datasets and literature in order to provide information regarding the relationship of victimization and delinquency in tribal communities; and to conduct a nationwide, web-based survey among Indian youth that will tell

us, in their own words, the true extent of the issue and give us hints as to how to address it. This paper presents results related to the first project goal.

Our two research questions ask the following:

1. What are the observed differences related to victimization, delinquency, substance use, sexual behavior, and mental health between American Indian/Alaska Native youth compared to youth of other categories of race/ethnicity?
2. What is the observed association between victimization and delinquency for American Indian/Alaska Native youth?

Methodology

The Centers for Disease Control and Prevention (CDC), in conjunction with state and local governments, and other agencies, has been monitoring health-risk behaviors in young adults approximately every-other year since 1991 with the Youth Risk Behavior Surveillance System. Data and further information on the study and its history are available on the CDC's website (CDC, 2008). Data in the YRBSS dataset include information regarding youths' participation in behaviors that are or may lead to violence or unintentional injury, substance use (including tobacco, alcohol, and other drugs), sexual behaviors, as well as eating and exercise habits (CDC, 2008).

Data from 2003, 2005, and 2007 were downloaded and concatenated into a single data file for this analysis, in order to maximize the number of responses from AI/AN youth available for analysis. Analysis of the weighted survey data was completed using SAS. Items were selected for secondary analysis based on their relevance to one of five categories including: (1) Violence or delinquent behaviors. (2) Substance use, (3) Sexual behaviors, (4) Experience of victimization, and (5) Suicide-related behaviors. Wherever possible, item responses were dichotomized in order to emphasize the differences between groups.

Findings

For the first research question, analyses were conducted comparing youth who identified themselves as American Indian or Alaska Native (AI/AN) with (1) youth who identified themselves as Caucasian, and (2) youth who identified themselves as African American or Hispanic. For purposes of this analysis, youth who identified a mixed racial or ethnic background were excluded from the analysis. A Chi-Square test was used to determine whether there were statistically significant differences between each group (AI/AN vs. Caucasian or other Minorities) on each of the dichotomized variables. A familywise Bonferroni correction was used in determining statistical significance within each category to compensate for the large number of statistical tests conducted. The analyses conducted for the first research question suggest that pervasive levels of disproportionality exist between American Indian/Alaska Native youth an array of risk items. These differences are most profound between the AI/AN and Caucasian youth populations, but also exist in numerous areas between the AI/AN and both African American and Hispanic youth.

For the second research question, only AI/AN youth were considered for analysis. Responses to each of the eight delinquency and violence items were compared with responses to each of the five victimization items, resulting in 40 pairs of items. Again, a Chi-square test was used to determine statistical significance in the association between the two items, and a Bonferroni adjustment was used to compensate for the large number of statistical tests. Results for the second research question suggest that a strong and consistent association exists between the experience of victimization and delinquent or violent behaviors for American Indian/Alaska Native youth, as measured by the 13 items selected from the YRBSS dataset.

With regard to violence and delinquency, the univariate analysis indicated differences between AI/AN youth and youth from other race/ethnic groups. AI/AN youth were more likely to carry a gun, participate in physical altercations, receive injuries in altercations, and participate in altercations at school than Caucasian youth. AI/AN youth were more likely than Caucasian youth to have tried cigarettes, participated in drinking under the age of 13, and to have tried marijuana and/or heroin. AI/AN youth were also more likely than Caucasian youth to have used marijuana at school, to have first used marijuana before the age of 13, and to have used a needle to inject drugs directly into their system. AI/AN youth were also more likely than Caucasian youth to have considered and/or planned a suicide attempt, and to have attempted suicide.

The analysis also describes a relationship between victimization and delinquency among AI/AN youth. Threat or injury at school was associated with carrying weapons and being injured in a physical fight. Being victimized by theft was associated with carrying weapons, and fighting as well as driving while under the influence of alcohol. Being hurt by a boyfriend or girlfriend was associated with carrying a weapon at school specifically, and participating in physical altercations. Having ever been raped was also associated with carrying weapons (but not guns), and participation in physical fights. It is not clear, however, that the associations between victimization and delinquency were stronger for AI/AN youth than for youth from other race/ethnic groups.

Conclusion

The findings highlight the challenges faced by AI/AN youth. Elevated levels of victimization, drug use, and suicidal behaviors indicate the need for improved and sustained access to effective interventions. Future research should focus on the development of culturally appropriate interventions designed to address the unique traumas experienced by youth living in AI/AN communities and policies that may perpetuate such experiences.

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Session 40 » 1:30 - 2:00 pm » Salon H

Diffusion of Trauma-Informed Policies and Practices among Mental Health Agencies

Presenting: Jeanne Rivard, Christine Walrath, John Gilford Jr. & Cynthia Hovor

Introduction

Several policy and program initiatives at federal, state, and local levels have arisen in recent years to respond to the need to integrate trauma-informed care into service systems, which would promote access to effective mental health and related social services, as well as standardized screening and assessment, early identification, prevention services, family engagement, and cultural competence and sensitivity to ethnic and racial differences (Cooper, Masi, Dababnah, Aratani, & Knitzer, 2007; National Center for Child Traumatic Stress, 2004; National Technical Assistance Center for State Mental Health Planning, 2003). Cooper and colleagues' (2007) recent review of policy and program initiatives that support children, youth, and families who experience trauma praises the new opportunities presented by these initiatives, but points out the pervasive gaps between the urgent need and the current status of policy

and practice. This paper sheds light on agency-level policies and practices targeted for children and adolescents that have been exposed to traumatic experiences. A secondary analysis of data from the National Impact Study component of the SAMHSA-funded cross-site evaluation of the National Child Traumatic Stress Initiative (NCTSI) was conducted to examine the diffusion of trauma-informed care into mental health agency policies/procedures, training programs, and service provision.

Methodology

The design for the National Impact study component of the cross-site evaluation of the NCTSI involves four annual cross-sectional surveys of agencies' policies and practices. Data used for the present analysis were collected from mental health agencies in 2006 and 2008. Respondent agencies were recruited through professional associations that represent state, county, and local organizations. The specific respondents were agency executive directors or their executive level designees.

The National Impact Study survey instrument was developed specifically to assess the diffusion of trauma-related knowledge and technology (e.g., information products, training packages, evidence based interventions) beyond the network of NCTSI-funded centers and communities to the larger multi-sector children's services arena. It inquires about the characteristics of agencies and their service populations; agencies' staff knowledge of the consequences of childhood trauma, needs of children exposed to trauma, and knowledge and use of trauma interventions; agencies' familiarity with and connections to the various NCTSI centers; and a series of questions concerning policies, practices, programs, and funding targeted for children and adolescents who have been exposed to traumatic experiences. The survey instrument was pre-tested in paper and web-based form and was adapted slightly based on pilot participants' feedback. Testing of the instrument, using the first survey administration data from 2006, showed high internal consistency (Cronbach's $\alpha = .89$) on scales measuring agencies' knowledge and use of trauma informed care, and policies and practices supporting trauma informed care. The survey was developed to be administered primarily in a web-based format, but respondents were also offered the alternatives of responding via hard copy or telephone interview.

Findings

In 2006 the response rate was 35% (702/2026), whereas the 2008 response rate was lower at 23% (567/2515). In both 2006 and 2008 mental health agencies reported that their staff had relatively high levels of knowledge about the consequences of trauma, the special needs of children affected by trauma, and about trauma interventions. The means on these items ranged from 3.5 to 4.4 on a five-point Likert type scale (1 = Not at all to 5 = A lot). Significant increases were found over time in mental health agencies' use of trauma-informed policies and procedures related to screening [χ^2 (1, $N = 1004$) = 15.40, $p < .001$], assessment [χ^2 (1, $N = 1013$) = 16.75, $p < .001$], and treatment [χ^2 (1, $N = 1005$) = 19.27, $p < .001$]. Although a greater proportion of agencies in 2008, than in 2006, reported actually providing staff training in these same areas, the difference was not significant.

With regard to service provision, 65% of the agencies in 2006, and 61% in 2008 reported that they offer specialized services for children affected by traumatic experiences. These agencies reported that in 2006, 55% of their population in need had access to the specialized trauma services; in 2008 the reported coverage was 59%. When asked in a

follow up question whether any of these specialized trauma services were evidence based practices, 60% of agencies in 2006 and 74% of agencies in 2008 reported that their trauma services were evidence based. Results of a chi square analysis showed this to be a significant increase [χ^2 (1, $N = 525$) = 5.77, $p < .05$]. The most frequently reported evidence based interventions were Trauma-focused Cognitive Behavior Therapy (TF-CBT), Abuse-focused Cognitive Behavior Therapy, and Adapted Dialectical Behavior Therapy for Special Populations. Other frequently reported evidence-based practices included: Parent-Child Interaction Therapy, Combined TF-CBT and Medication Management, TF-CBT for Childhood Traumatic Grief, Psychological First Aid, and Cognitive Behavioral Intervention for Trauma in Schools.

Conclusion

Results suggest growth in the uptake, by mental health agencies, of trauma-informed policies and of trauma-focused evidence-based practices for children affected by traumatic experiences. Further analyses will be conducted of the 2006 and 2008 data sets to examine the mechanisms of diffusion. For example, does the packaging and training of EBP's increase the likelihood of agencies' uptake of trauma-informed care? Do agencies' relationships with the NCTSI increase the likelihood of their uptake of trauma-informed care? What are the facilitators and barriers encountered when attempting to integrate trauma-informed care into service systems?

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Session 40 » 2:00 - 2:30 pm » Salon H

Evaluation of an Intervention for Adolescent Girls with Trauma Related Disorders

Presenting: Meredith Elzy

Acknowledgement: This effort is being completed by a team of researchers affiliated with the Louis de la Parte Florida Mental Health Institute and is funded by the Florida Agency for Health Care Administration (AHCA).

Introduction:

Recent epidemiological research suggests that stressful and traumatic childhood events are both plentiful and consequential. In a sample of over 17,000 adults randomly selected through a health management organization, over half of them reported childhood exposure to at least one major family stressor; furthermore, as the number of significant family stressors a child experienced increased, so did maladaptive physical and emotional health patterns in adulthood (Felitti, Anda, Nordenberg, Williamson, Spitz, et al., 1998). This evidence has directed researchers to look for interventions that may help disrupt this pattern. The current paper reports on an evaluation study of one such intervention and will present the methodological design of the study as well as some preliminary research findings.

The Triad Girls' Group (LeVasseur & Clark, 2003) is an intervention designed to help at-risk adolescent girls develop age appropriate coping skills, healthy interpersonal relationships, and capacities for self-care. It was first developed as an adaptation of the Triad Women's Group to help adolescent girls with histories of substance abuse, mental health issues, violence, and trauma. The primary goals of the Triad Girls' Group are to empower the participants to improve their mental health, to support them in their survival and healing from violence and trauma, to identify the strengths that have helped them to survive, to assist them in discontinuing or avoiding substance use, and to increase their chances for success in school, relationships, and their future (LeVasseur & Clark, 2003).

The Triad Girls' Group curriculum was developed in response to community providers' recognition of the need for an integrated gender-specific intervention addressing substance use, emotional problems and trauma related disorders and has been shared through implementation and trainings in the Tampa Bay area. Anecdotal evidence suggests that

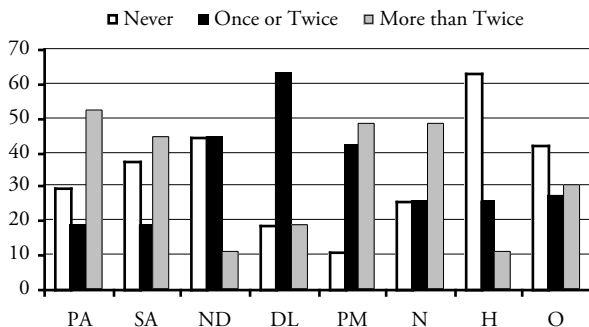
it is successful in helping adolescents develop important life skills. The current study is the first empirical evaluation of the group's effectiveness in enhancing coping skills, improving self-esteem, decreasing mental health concerns, and decreasing drug and alcohol use.

Methodology

Participants in the Triad Girls' Group evaluation study were recruited from four out-of-home care facilities within the Tampa Bay area. Staff members at each facility selected girls they felt would benefit from the group curriculum and objectives. The current study includes pre-test data collected before the groups began as well as follow-up evaluations scheduled to be completed at 3 months, 6 months, 12 months, and 24 months. These evaluations are designed to measure changes in participants' presentation in the following domains: abuse/trauma symptoms, psychosocial functioning, substance use, mental health, and coping skills.

Initial interviews were conducted to gain insight into the participants' traumatic childhood experiences, coping resources, psychosocial functioning, and current mental health functioning. Approximately 58% of the girls assessed for this study have been living in an out-of-home-care placement or facility for the majority of the past year. In addition, all but one participant endorsed the experience of potentially traumatic events during their lifetime including, but not limited to, sexual abuse, physical abuse, psychological maltreatment, neglect, a natural disaster, hospitalization with perceived life threat, and/or the death of a loved one. The prevalence of these events within our current sample can be seen in Figure 1.

Figure 1
Total Trauma Exposure as Reported by the TSRA (Briere, in press)



Findings

The impact of these traumatic experiences may best be explained by the pre-intervention level of mental health functioning and coping strategies of the participants. Participants were administered the Youth Self-Report (YSR; Achenbach, 1991) during the pre-test assessment period. The mean scores indicated that the girls met the clinical range ($T \geq 67$) for five subscales: Conduct Disorder, Attention Problems, Aggressive Behaviors, Externalizing Behaviors, and Total Problems. In addition, the mean scores were in the borderline clinical range ($T \geq 64$) for Post Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Social Problems, and Rule Breaking Behaviors. Results of the drug and alcohol use module from the child and adolescent screening inventory for residential care, 2nd edition (CASI; Sunseri, 2005) indicate that alcohol and marijuana use for this sample is above the national average for girls within this age range with almost half of the participants reporting alcohol and marijuana use during their lifetime.

Conclusion

It is this triad of issues—history of trauma, substance abuse, and emotional problems—that leads to the necessity of comprehensive, integrated treatment approaches that incorporate all aspects of healthy functioning. The purpose of this paper presentation is to evaluate the effectiveness of one such intervention. Preliminary data comparing pre-group scores and three month follow-up scores suggests that the girls participating in the TRIAD groups are demonstrating an increased use of approach coping skills ($t = 1.99, p = .05$). However, the anticipated reduction of trauma symptoms does not appear to be taking place ($F = .003, ns$) and their overall use of coping skills did not increase ($t = 1.270, ns$). It is possible that treatment fidelity issues arising due to short-term placements in the facilities may be partly responsible for the lack of significant findings.

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An Evaluation of Boys Town's Family Preservation Program

Presenting: Annette Griffith, Kristin Hurley, Stephanie Ingram & Claudine Cannezzaro

Acknowledgements: We would like to thank the staff at both Boys Town and the University of Nebraska-Lincoln, Center for At-Risk Children's Service for their participation in the data collection process. We would also like to thank the families who participated in this study.

Introduction

According to the U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, 3.6 million cases of suspected child abuse and neglect were reported to child protective service agencies in 2006 (USDHHS, 2008). Almost a million of these cases were substantiated. For these families, in-home family preservation programs have become a commonly used intervention for the prevention of child out-of-home placements (Cash & Berry, 2003). This is evidenced by the increasing numbers of families who are being served in in-home settings.

Findings from research on family preservation programs have been mixed, with some finding positive effects and others either no effects or negative effects (Kauffman, 2007). Outcomes of family preservation programs are most often assessed based on re-referral to child welfare services or child removal from the home. However, these outcomes are often influenced by other factors (e.g., changing state policy; resources of child protective agencies) and do not necessarily give a clear indication of family improvement or of the effectiveness of family preservation programs (Cash & Berry, 2003). Therefore, the purpose of the current study was to evaluate a commonly used family preservation program using outcome measures that were more indicative of family progress and which may serve as precursors to re-referral or out-of-home placements. Specifically, the current study sought to identify levels of child behavior and strengths, family functioning, parenting practices, and parenting stress prior to participation in a family preservation program and examine changes that occurred across these constructs following participation.

Method

Family Preservation services

The Boys Town Family Preservation services program is based on the Teaching Family Model used within the Boys Town residential program. The goal of the program is to provide families with supports and skills to prevent child removal due to issues of abuse, neglect, and/or family violence. The program is delivered in the family home by a trained family consultant over a period of six to eight weeks. During this time, the family consultant works with the family to identify and build on strengths, teach new skills, and serve as a bridge to community services that can serve as on-going support.

Participants

Thirty-eight families from the West Palm Beach area participated in the study. Families were referred through a child welfare services agency for issues of abuse, neglect, and/or domestic violence. Each family that participated identified one target child for data collection purposes. Forty-seven percent of the children in the study were male and they had an average age of 9.37 years ($SD = 3.48$). Half of children in the sample were African American (50%), one quarter were Hispanic, and one quarter were Caucasian. They presented with a high number of school-related risk factors (e.g., suspensions, and being retained in grades) and had a higher than expected number of school moves ($M = 2.32$, $SD = 2.24$). Basic demographic information on parents and household composition will be available at the time of the presentation.

Design

Data were collected by in-home family consultants using a pretest/posttest design. Pretest data were collected during the first meeting following the obtaining of family consent. Posttest data were collected during the last family meeting once services were completed. Each data collection session lasted approximately one hour. During this time, family consultants read the instructions and the items from each of the measures to families, who responded verbally. Family consultants recorded the responses.

Measures

Six measures were used to collect data on child educational history, child behavior and strengths, family functioning, parenting practices and beliefs, and parental stress: (1) Child Education History Questionnaire (developed for this study); (2) Child Behavior Checklist (Achenbach & Rescorla, 2001); (3) Behavioral and Emotional Rating Scale (Epstein, 2004); (4) Family Assessment Device (Epstein, Baldwin, & Bishop, 1983); (5) Parenting Practices Interview (Webster-Stratton, Reid, & Hammond, 2004), and; (6) Parenting Stress Index (Abidin, 1995). Measures were selected due to a match between the constructs covered by the measures and the goals of the Family Preservation program.

Findings

At the time of intake, families reported that children displayed borderline levels of problem behavior and had below average strengths across several areas. In addition, they reported unhealthy, or near unhealthy, levels of family functioning, that they were struggling with some aspects of parenting, and had clinical levels of stress in relation to their roles as parents. At the time of departure, however, families reported that child behavior and strengths had improved significantly (ESs of .35 to .52 and .19 to .50 respectively), increasing to levels of normal and average functioning. They reported significant improvements in all areas of family functioning (ESs of .40 to .50), and across the majority of areas for parenting practices (ESs of .21 to .95) and parenting-related stress (ESs of .31 to .52).

Conclusions

Findings indicate that families involved in the Boys Town Family Preservation program presented with significant concerns across each of the areas studied. This indicates that the families involved in the program experienced a broad array of risks and needs. However, following the intervention program, families reported improvement across all areas, many to levels of normal, or near-normal, functioning. Although it is unclear how these outcomes may have related to more long-term outcomes such as re-referral or out-of-home placement, they indicate that the Family Preservation program may be beneficial in reducing the levels of risk that these families experience.

There are several limitations to this study, including the pre/post design which lacked a comparison group, involvement of participants from only one site, and the use of self-report measures collected by a direct service provider. However, with these limitations in mind, the Family Preservation program evaluated in the current study appears to be a promising approach for working with families involved with child protective services.

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Session 41 » 1:30 - 2:00 pm » Salon I

Building a Research Agenda: Implementation Research and Wraparound Literature

Presenting: Rosalyn M. Bertram

Contributing: Jesse C. Suter, Eric J. Bruns & Koren E. O'Rourke

Introduction

Advisors to the National Wraparound Initiative's (NWI) research and evaluation group analyzed wraparound literature through a framework suggested by the National Implementation Research Network (NIRN). Prior to analysis we assumed that much had been published regarding model definition, model fidelity and outcomes but that many core implementation components were less well-addressed in wraparound literature. Advisors believed such analysis could inform the field and suggest a wraparound research agenda.

Briefly, the NIRN framework (Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005) suggests that to implement a program, core intervention components to be addressed include a clear definition of the model, characteristics of the program's target population, how the model addresses them, why alternative models were not selected, model theory base and theory of change. Implementation of the intervention model is driven through core implementation components that include organizational context and readiness, facilitative administrative structures, systems level interventions to support direct service, model fidelity assessment, staff selection, training, coaching, and selection of purveyors who through consultation and training support these implementation drivers. NIRN describes implementation as a 2-4 year process that unfolds through stages of exploration and adoption, program installation, initial implementation, full operation, innovation, and sustainability that produce both intervention and implementation outcomes.

Method

Initial review of wraparound literature focused upon books, monographs and peer-reviewed publications. Unlike the NIRN study, this review wasn't limited to publications reporting empirically derived outcomes. We were interested in any and all descriptions of wraparound interventions and implementation. Diverse databases were searched. We first examined literature published since 2000. References from these publications augmented the search of literature published before 2000. A third search reviewed papers published in conference proceedings from the Tampa Systems of Care and Portland Building on Family Strengths Conferences, key venues for wraparound dissemination. We searched websites of the research and training centers (RTC) associated with sponsors of these conferences for publications grounded in the literature. These papers were compared with literature already identified in books,

monographs or peer-reviewed publications. Conference or RTC papers subsequently published in a journal, monograph, or book were removed from further analysis.

Through each search, this author and three research assistants reviewed publications separately to determine which core components were addressed. These separate analyses were compared. Differences of placement were discussed until there was agreement. This analysis was shared with NWI's research and evaluation group who could recommend overlooked literature or similarly question and resolve placement of literature in the framework. Finally, our review was shared with NIRN's co-director, Dean Fixsen, who recommended specific language for core components and order of presentation. At last year's Tampa conference a brief symposium paper reported initial results from review of nearly 70 publications. We have now completed this stage of the study having reviewed twice that number.

Findings and Implications

Results are illustrated in Figures 1 and 2. Many implications for future research, too numerous for space limitations, will be discussed in a *Journal of Child and Family Studies* article (Bertram, in review).

Model definition ($n = 20$), fidelity ($n = 25$), and outcomes ($n = 48$) have received the most attention. However, wraparound's target population has been asserted rather than systematically studied in relation to its core intervention components. This oversight may be due to how initial wraparound programs were funded as an alternative to more restrictive, expensive categorical responses to severe child behaviors. SAMHSA systems of care grants may have amplified this assumption with their focus upon systems level change that supports using wraparound to improve outcomes for this population.

Figure 1
Core Intervention Components
 $N = 60$

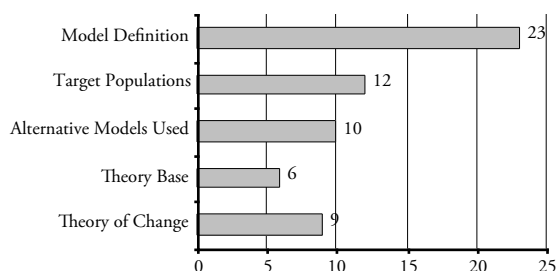
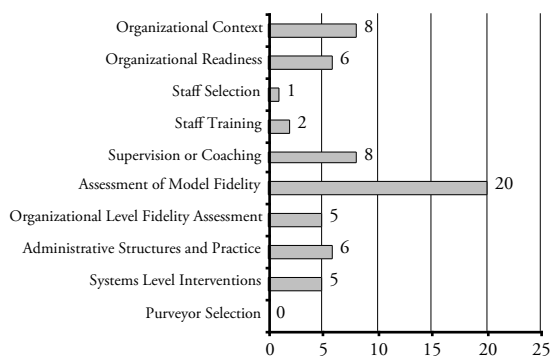


Figure 2
Core Implementation Components
N = 61



What are specific characteristics of families with children who display severe emotional and behavioral disorders and what aspects of wraparound address these characteristics? Before this year there was no published theory of change for wraparound. Closer examination of this assumed target population's characteristics through this theory of change should suggest other populations for which wraparound may be an appropriate intervention model (Walker, 2008).

Such study would refine this initial theory of change and perhaps suggest systematic study of the theory base for wraparound team process and its value-based principles. Both ecological theory (Walker, 2008) and ecological systems theory (Bertram & Bertram, 2004) were identified as wraparound's theory base. This difference may not be semantic and may have relevance for the focus and process of team assessments, choice of services and design of interventions, as well as for staff selection, training, supervision or coaching, fidelity assessment and other core implementation components.

For example, wraparound innovations in the literature focused upon team development and process, the focus of team assessment and service interventions. These innovations suggested that functional assessment

of behavior and/or ecological systems theory provide greater clarity for designing strengths-based interventions. But what are meaningful strengths in families or their natural supports and how are they actually applied in wraparound service plans? Our review found no such examination.

Core Implementation Components

Perhaps the most notable implementations components were those that received little or no systematic attention in the literature such as staff selection and training and purveyor selection. How are specific knowledge and skills developed through what training curriculum, methods, and purveyors? How does the educational or experiential background of staff influence these outcomes? Programs around the world hire consultants, but there has been no discussion in the literature of what purveyor focus, curriculum, methods or qualities produce what outcomes with what staff in what organizational contexts. This may explain the lack of literature on program installation.

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Session 41 » 2:00 - 2:30 pm » Salon I

Evaluation of Wraparound Services within Erie County

Presenting: Brian Pagkos, Heidi Milch & Mansoor Kazi

Introduction:

Youth with serious emotional disturbances are often involved with a multitude of service providers, such as mental health agencies, education assistance, child welfare or social service departments, and juvenile justice systems (Burns & Friedman, 1990). The wraparound system of care provides a comprehensive approach to mental health treatment and utilizes a coordinated network of services to meet the multiple and changing needs of children and their families. Community Connections of New York (CCNY) evaluates the effectiveness of wraparound services bi-annually for all of Erie County, NY and quarterly for each care coordination agency providing wraparound services within Erie County. The presentation will provide a synopsis of results from CCNY's recent countywide evaluation, with examples of translating findings into quality improvement practices.

Method

Approach

We explored the intervention using real-time evaluation techniques, which include capturing the context and process of an intervention and relating these components to the achievement of outcomes. This results in an understanding of where the intervention is more or less likely to be effective (Kazi, 2003). Utility of results is ensured through applying tenets of utilization focused evaluation such as incorporating stakeholders throughout process, framing dissemination to meet their needs, and iteratively working with program staff to develop quality improvement strategies.

Sample

Enrolled case sample. Consisted of $N = 256$ youth enrolled in Erie County wraparound as of April 15th, 2008 who had at least two Child and Adolescent Functionality Assessment Scale (CAFAS) records (Hodges, 1995). Mean age at referral was 13.40 ($SD = 2.94$), 60.2% ($n = 154$) were male, 50% ($n = 128$) were White, 23.8% ($n = 61$) Black or African American, 9% ($n = 23$) Puerto Rican, 13.7% ($n = 35$) Biracial, and 3.5% ($n = 9$) 'other'. The average length of stay was 8.29 months ($SD = 5.08$).

Discharged case sample. Consisted of all youth who were discharged from the wraparound program in 2007 ($N = 289$). Mean age at referral for this group was 13.70 ($SD = 2.76$), 63% ($n = 183$) were male, 49% ($n = 142$) were White, 28% ($n = 80$) Black or African American, 9% ($n = 27$) Puerto Rican, 7% ($n = 21$) Biracial, and 2% ($n = 5$) 'other.' The average length of stay was 11.4 months ($SD = 7.26$).

Analyses

Enrolled case sample. The primary outcome for this group was change in the CAFAS, defined by recoded linear trends of repeated measure data. Paired samples t -tests were used to determine the magnitude of change between first and last CAFAS measures.

Discharged case sample. The primary outcome was whether the case was discharged with child and family team goals met. Descriptive analyses and crosstabulations between this outcome and demographic variables were conducted.

Both samples. Spearman correlations between outcome achievement and contextual variables (i.e., demographics, service receipt details) were calculated to examine patterns. Statistically significant correlations alert us to variables that might be influencing the outcome. The last step in the analysis is to determine what variables are influencing the outcome. Significant results from bivariate analyses are entered into a forward conditional binary logistic regression model in which odds ratios or likelihoods of outcome achievement are calculated.

Findings

Enrolled Case Sample

About half of the youth in the sample ($n = 119$) were scored as having moderate impairment as noted by the total CAFAS at baseline. Results of the paired sample t -test were significant and desirable for total CAFAS scores ($t(241) = 14.93, p < .01$), $d = .346$, indicating an overall decrease in impairment in functioning. Seventy-five percent ($n = 188$) of cases were displaying improvement in their total CAFAS at the time of analysis and 63% ($n = 149$) of youth decreased their level of impairment as noted by total CAFAS scores when comparing first and last assessments.

Youth who did not experience a placement in a residential setting during their wraparound length of stay were 2.7 times more likely to improve in total CAFAS scores compared to those who experienced such

a placement ($r_s(244) = -0.190, p < .01$; $Exp(B) = 2.73, p < .01$). Youth who received in-home treatment services were two times more likely to improve in their CAFAS behavior subscale compared to those who did not receive the service and improved ($r_s(240) = .189, p < 0.01$; $Exp(B) = 1.90, p < .05$).

Discharged Case Sample

In the sample, 51.6% ($n = 149$) of youth discharged in 2007 were discharged with child and family team goals met. Cases that received skills development/mentoring services were 2.4 times more likely to be discharged with goals met than cases that did not receive this service ($r_s(282) = .301, p < .01$; $Exp(B) = 2.42, p < .05$). Cases that received monies assisting with the purchase of clothing and for personal needs were almost 5 times more likely to be discharged with goals met than cases that did not receive them ($r_s(282) = .256, p < .01$; $Exp(B) = 4.96, p < .01$). Youth who were re-coded as being "White" at referral were 2.5 times more likely to be discharged with goals met at discharge compared to youth re-coded as being "Not White" ($r_s(289) = 0.163, p < .01$; $Exp(B) = 2.50, p < .05$).

Conclusion and Opportunities

Use of real-time evaluation results delivers essential program information and, when combined with tenets from utilization-focused evaluation, can lead to program development and substantial improvement in outcomes for youth. Examples of suggested quality improvement initiatives, the full details of which will be shared in the presentation, were: addressing disproportionate outcomes for White versus non-White youth and understanding practitioner rationale for service selection including, but not limited to use of residential treatment, in-home treatment and skill building.

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Session 41 » 2:30 - 3:00 pm » Salon I

A Rural, Non-Profit Model for Workforce Wraparound Readiness in Systems of Care

Presenting: Ira Lourie, Jeff Folsom & Meghan Gallagher

Introduction:

Effective wraparound implementation begins with the direct-service workers who develop and maintain care plans that adhere to wraparound philosophy and promote best practices (Burns, 1999; Sheehan, Walrath, & Holden, 2007). Successful application of wraparound must begin with the workforce. Huang, Macbeth, Dodge and Jacobstein (2004) maintain that workers who implement care in collaboration with children and families are the most important avenue for effective service delivery. Wraparound fidelity thus depends upon training programs that develop worker knowledge and commitment to applying a wraparound philosophy in measurable, value-based practices. A.W.A.R.E. Inc. is a non-profit organization that uses a wraparound, unconditional care philosophy to serve the needs of children and families across Montana's vast and diverse rural areas. This paper presents a case study of workforce development efforts including data on the agency's initial process and outcome measures.

The President's New Freedom Commission on Mental Health (2003) emphasizes "adequate training for front-line providers and professionals" (p. 19) to integrate research into practice. The Commission also recognizes that disparities exist between mental health services delivered in urban areas as opposed to rural or geographically remote areas. Many programs using wraparound services are implemented in resource-rich environments that benefit from grant, university or other outside supports that rural areas lack. These programs have seen success in forwarding systems of care and wraparound philosophies but are not readily replicable in rural areas lacking similar resources. Further, the programs often involve relatively small numbers of employees and families.

A.W.A.R.E. is committed to training more than 1200 employees annually on implementing its unconditional care philosophy across Montana's 147,046 square miles. This paper examines organizational initiatives used to facilitate a wraparound ready workforce including a review of employee fidelity measures to the philosophy and preliminary data on family outcomes.

Methodology

A.W.A.R.E. implements both qualitative and quantitative strategies that will ready its workforce to deliver services within an unconditional care philosophy. The longitudinal plan utilizes a chronological case study format following specific indicators that measure outcomes and inform future directions.

Wraparound Identification

- **Researching Wraparound** – Adoption of the wraparound ideology required an understanding of its philosophy and consideration of the exhaustive research as to what constitutes best practices.
- **Professional Consultation and Extensive Training** – This training created discussion and some effort toward implementation of wraparound philosophies but did not engage enough staff nor impact enough families across time to achieve organizational goals.
- **Defining Unconditional Care Principles (UCCPs)** – An agency-wide commission was appointed to define how unconditional care could be manifested within the agency, leading to development of a statement of unconditional care and a process to test the statement's validity. The principles are the backbone for agency implementation of wraparound philosophy and workforce development.

Training the Workforce

- **Redesigning the Policy and Procedure Manual** promotes staff use of language/behaviors associated with the UCCPs in day-to-day practice.
- **Continued Professional Consultation and Training** places special emphasis on child and family team meeting training, creating meaningful and measurable strength-based plans.
- **Internal Marketing and Promoting** strategies highlight the UCCPs and include: (a) annual awards for employees whose work embodies the principles; (b) proliferation of the principles through business cards, posters and banners; (c) distribution of literature; and (d) an internal newsletter that includes Dr. Ira Lourie's regular feature "Shrink Wrap."
- **Corporate Congress**, a "ground-up" organizational development process, uses a cross-section of direct care workers annually to engage in strategic planning designed to implement the UCCPs.
- **Formalized Staff Support** requires internal support to apply the UCCPs in practice. A.W.A.R.E. started Out of State Placement Staffings (OSPS) to address the large number of youth receiving services out of state.
- **Redesigning Outcomes Management and Quality Assurance Approaches** utilizes indicators that measure adherence to the UCCPs.

Findings

Workforce Fidelity to Wraparound uses three tools to gauge wraparound readiness in the workforce: (1) quality assurance reviews; (2) client satisfaction outcomes, and (3) community-based care outcomes.

Table 1 summarizes Quality Assurance Reviews of 668 charts to systematically measure 12 staff behaviors and compliance with the UCCPs, setting forth a feedback loop of trainings designed to correct areas of low compliance.

With regard to Client Satisfaction Outcomes, employees purposively selected 110 families in 2007 to complete client satisfaction surveys to determine staff adherence to the UCCPs. The 66 families who returned the surveys communicated three core messages for staff to consider when applying the principles in everyday practice: (1) listen; (2) respond to needs; and (3) include client in team collaboration. The agency surveyed 100 more families in 2008 and is compiling the results.

Lastly, to gauge wraparound readiness in Community-Based Care Outcomes, additional evidence of employee fidelity to the UCCPs was demonstrated by the staff's commitment to serve children within their families, thus decreasing out-of-home placements in group homes, foster care and residential treatment centers. Baseline data convenience sampled over the four-year period prior to incorporation of the principles showed an average out-of-home placement rate of 23.75%; currently the rate is 16.2%.

Despite the downward trend in out-of-home placements, a spike remained in out-of-state residential placements. Figure 1 demonstrates that the agency's October 2007 implementation of the OSPS process substantially reduced out-of-state residential treatment placements.

Conclusion

Existing case study information and outcome indicators outline a practice model that can inform the policies and practices pertaining to children receiving mental health services in rural areas and demonstrate that A.W.A.R.E. is closer to realizing wraparound fidelity in practice.

Tuesday – 1:30

Table 1
Quality Assurance Focus Areas

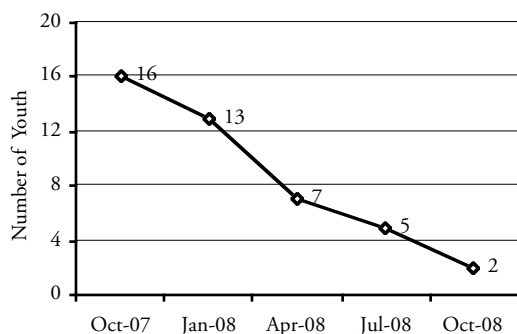
<i>Unconditional Care Principles</i>	<i>Focus Areas</i>	<i>Employee Compliance Rate 2007</i>	<i>Employee Compliance Rate 2008</i>
Strengths are the key to Success; I'm Ok, you're Ok; Everything is normal until proven otherwise	Person Centered, Wraparound Approach Evident	96.49%	98.35%
	Treatment Plan Reflects Strengths	95.55%	95.05%
	Progress Notes Reflect Strength-Based Approach	96.1%	96.7%
Be Agents of Change	Strength-Based Outcomes Are Tracked	Not Assessed	
	• Strengthening Family Skills Completed		67.6%
	• Completed Child Behavior Assessment		68.18%
	• Child and Family Outcomes Completed		65.5%
Families Are the Most Important Resource Lighten Up and Laugh	Treatment Plan Reflects Family Focused Language	90.82%	86.78%
	Family Voice and Choice Evident	Not Assessed	
	• Family Meeting Prep Tool Completed		66.53%
	• Areas of Needed Assistance Identified		85.13%
	• Completed Invitation List		83.47%
It Takes a Team	• Meeting Format Reviewed		82.23%
	Family Team Includes Natural Supports	85.22%	73.97%
	Treatment Plan is Signed by Child and Family	82.88%	77.69%
The Connection With Communities is Vital Take On and Stick With the Hardest Challenges	Team Meeting is Face-to-Face	91.79%	97.52%
	Treatment Plan is Least Restrictive and Culturally Appropriate	97.66%	98.76%
	Crisis Plan Present	76.77%	69.83%
Strive For the Highest Quality of Care	Measurable Treatment Plan Interventions	92.96%	56.55%

Quality assurance compliance rates and client surveys collected over a short time period clearly indicate the need to continue education and support staff in areas that will improve the commitment to a wraparound philosophy. A.W.A.R.E. is at a reformative stage of developing its analytical framework to bring family participation into the evaluation process and to build upon its initial tracking systems. Continued, critical analysis of this approach, however, is needed in order to strengthen the direction of agency research and effective service delivery in future years.

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Figure 1
Youth Out-of-State Placements



System of Care Community Plans for, and Caregiver Perceptions of, Evidence-Based Treatments

Presenting: Kurt Moore & Carolyn Lichtenstein

Contributing: Sylvia Fisher

Introduction

This paper will share findings from the national evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program. The data analyzed include: information from communities about specific evidence-based treatments and practices that are being implemented; plans, attitudes and decision-making processes regarding their use and implementation; and caregiver reports of their service providers' explanations about the evidence and clinical experiences supporting the services that children and families receive.

The national evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program is conducting an Evidence-Based Practices Study with grant communities funded in 2005 and 2006. This paper will share findings from two sub-studies of this study, as well as information drawn from the System of Care Assessment, which assesses the extent to which grantee communities implement the core SOC principles.

In this paper, the term evidence-based treatment (EBT) is defined as "any practice that has been established as effective through scientific research according to a set of explicit criteria" (Drake et al., 2001). Thus, EBT refers to a specific treatment approach. The APA recently made a clear distinction between EBT and evidence-based practice (EBP), which is defined as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA, 2005, p. 5). The EBP/EBT topic provokes robust debates within community leadership teams. One of the conflicts driving these debates is the complex relationship between the values of EBTs and those of the systems of care movement:

...while evidence-based practices, systems of care, and individualized care appear to be conceptually compatible with each other, and have something to offer each other, there seems to be relatively little integration of them in actual practice (Friedman & Drews, 2005, p3).

Grant communities funded in 2005 and 2006 are required by the RFA to emphasize the delivery of effective clinical interventions. The continued investigation of EBTs and their application and integration within systems of care is particularly important in understanding how to further facilitate the provision of effective services for diverse populations with serious emotional needs. An essential component of the dialogue surrounding EBTs in child and adolescent mental health is the perspective that families offer regarding EBTs. The practical needs and experiences of caregivers and other family members have become a key focus of attention in the effort to understand how best to implement EBTs in system of care communities.

Methods

Data presented here were collected from grantee communities funded in 2005 and 2006 via two national evaluation studies. *The System of Care Assessment*, which assesses the extent to which grantee communities implement the core SOC principles, collects data from communities about specific EBTs and EBPs implemented. *The Community Plans Substudy* (CPS) of the *Evidence-Based Practices Study* involved conference calls, during the first two years of grant funding, with the project director, lead evaluator, clinical director, and a family representative of participating grant communities. These calls were conducted to discuss

plans, attitudes and decision-making processes regarding the use and implementation of EBTs and PBE approaches with system of care communities.

In addition, data were collected from caregivers participating in the *Longitudinal Child and Family Outcome Study (Outcome Study)* at all communities funded in 2005 and 2006. The Multi-Sector Service Contacts-Revised (MSSC-R) is an instrument used in the *Outcome Study* interview to assess caregiver perceptions of services provided to their child and their effectiveness. The Evidence-Based Practices Experience Measure (EBPEM) is an addendum to the MSSC-R, which asks caregivers about their service providers' explanations about EBTs. Data from both instrument components will be included in this study.

Caregiver interview data submitted to the national evaluation through December 2008 will be analyzed, and the results will be reported (as described below).

Findings

Participants in the CPS voiced some strong opinions about the use of EBTs. Participants mentioned a wide range of attitudes and beliefs, often conflicting. This presentation will discuss these findings in detail. Analyses of Outcome Study caregivers' attitudes and experiences indicate several trends at 6 months.

The majority (71%; $n = 626$) of respondents reported that being informed about the research evidence demonstrating the effectiveness of services received by their child or youth was either very or extremely important; 96% of respondents felt that knowing the research evidence about services received was at least somewhat important. Despite this high percentage reporting the value of research evidence demonstrating service effectiveness, 32% ($n = 346$) of respondents reported that they were not informed about the research evidence relative to the effectiveness of those services received by their child.

An even greater majority (79%; $n = 691$) of respondents reported that it was very or extremely important to be told about the provider's previous experiences with effective services for children and youth. However, 24% ($n = 265$) of respondents reported not being told about the provider's previous experiences with a service.

Caregivers who were not informed about the research evidence supporting service effectiveness were significantly less satisfied with services received by their child and family ($t = 9.46, p < .001$). Additionally, those caregivers who were not informed about their service provider's experiences with the effectiveness of services were also significantly less satisfied with services ($t = 12.41, p < .001$). Overall, satisfaction scores were significantly correlated with caregiver reports of how important it was to be told about the research evidence supporting the services delivered ($t = 0.08, p < .001$) and the provider's experiences with the effectiveness of services with children and youth who have problems similar to those of the caregiver's child ($t = 0.17, p < .001$). This finding has meaningful implications for the program at both the national and local levels.

Conclusion

As Friedman and Drews (2005) described, there seem to be two common motivators for the adoption of EBTs. State policies and settled lawsuits provide one motive. As a participant noted, their site did not have to undergo an extensive and thorough decision-making process about which treatment approaches to use, since their state mandated

several EBTs. The other motivator stemmed from dissatisfaction with existing services, sometimes driven by data illustrating their failure to meet the needs of some families and children. Neither motivator guarantees a smooth integration of evidence-based treatment approaches with core system of care values, nor with local contexts. This presentation will share data that should illuminate some of these challenges, and their impact on youth, families and communities.

Session 42 » 2:00 - 2:30 pm » Salon J

Factors Associated with Perceptions of Need for Child and Adolescent Psychiatrists

Presenting: Cathleen Lewandowski & Lara Kaye

Contributing: Lynn Warner

Introduction:

Policymakers' decisions about program development and resources required to support a comprehensive system of care hinge upon accurate estimates of the need for child and adolescent psychiatric services. Though there are a variety of different ways to conceptualize need, a useful framework was originally developed by Bradshaw (1972) with regard to social needs. The framework proposes four categories to estimate need as follows: (1) comparative need estimates rely upon demographic and epidemiological data, such as prevalence of mental health disorders and are among the most common found in research on studies of unmet need; (2) expressed need relies on consumers' use of available services from utilization statistics; (3) felt need draws upon individuals' perceptions of their need for services, and; (4) normative need estimates come from the assessments of experts, such as psychiatrists and other mental health providers.

Each approach serves a particular purpose and comes with its own bias (Mechanic, 2003). Though imperfect, normative need (perceptions of experts) is not often presented in published research on gaps in children's mental health services, but may be an important resource for policymakers. Given their unique location in systems of care, mental health providers and service administrators can draw upon many utilization and client tracking data systems to assess service need.

While a few studies have reported on mental health professionals' perceptions of the need for children's mental health services (e.g., Campbell, Kearns, & Patchin, 2006), the factors that may influence these experts' perceptions are largely unexamined. The purpose of this study is to describe mental health administrators' perceptions of the need for child and adolescent psychiatrists (CAPS) in New York, and examine key normative and comparative factors that may be associated with their perceptions. The study contributes to the literature by describing a county-by-county assessment of need for CAPs in one state, and by providing insight into specific factors that may influence their perceptions.

Methodology

Sample

Study participants were community mental health directors, commissioners, or an individual with comparable knowledge of mental health services in their county. The total sample for the study was 58, or one administrator from each county in New York. Surveys for the seven largest counties, including New York City, included only a subset of the entire need assessment battery. Therefore, data from these counties were not included in the analyses reported here, leaving a sample size of 51.

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Data Collection

Both primary and secondary data sources were used. The research team developed a telephone survey to collect key demographic data on participants and information on administrators' perceptions of the need for child psychiatrists and child and adolescent mental health services within their county. Secondary data, collected from national and state level databases, were included to provide county level demographic information.

Variables

The dependent variable was participants' reported need for CAPs in their county based on responses to the question, "Does your county need any additional CAPs and if so how many?" The independent variables reflecting normative factors, or the participants' frame of reference, were gender and job title. Independent variables reflecting comparative need included a range of county demographic information (e.g., proportion of youth population, proportion of population living in poverty, suicide mortality rates, median family income, prevalence of mental disability). Control variables included current number of CAPs and availability of inpatient beds.

Analysis

Univariate and bivariate statistics were used to describe the sample and number of CAPs needed and to identify variables for the multivariate analysis. Given the relatively small sample size, only variables significant at the bivariate level were included in the multivariate model. Multivariate analysis was used to assess the relative weight of each factor in predicting participants' perceptions of the need for CAPs.

Findings

Nearly all the counties (92%) reported that they needed additional CAPs; on average counties reported needing two additional CAPs. Both normative and comparative factors were associated with participants' perceptions of the need for CAPs in their county. At the bivariate level, need for CAPs was significantly associated with the following independent variables: participants' job title; suicide mortality in 10 – 19 year olds; total population; families with children under age 18 years living in poverty; median family income; 5-15 year olds with mental disability; the number of CAPs, and; whether or not inpatient mental health beds were available within the county. In the multivariate analysis, whether or not inpatient mental health beds were available within the county, participants' report of the number of CAPs currently available in their county, and median family income were significantly associated with their estimates of the need for CAPs ($R^2 = 4.99$, $F = 5.2$, $p < .000$).

Conclusion

Though often dismissed as biased, experts' perceptions of need may be an important source of information for planning in public systems of care. Results of this study point to current capacity and county-level demographic information, rather than personal demographics or job status as significant influences on estimated need. One limitation of this study is that the analysis includes normative and comparative indicators of need, but does not include indicators of felt or expressed need. Thus, future research may benefit by investigating the extent to which felt and expressed need informed the study participants' perspectives.

Session 42 » 2:30 - 3:00 pm » Salon J

Understanding Community-Based Administrators' and Clinicians' Perspectives on Evidence-Based Treatment Implementation

Presenting: Amy Herschell

Contributing: Bradley Stein & Jane Kogan

Introduction

Efficacious psychosocial treatments for mental health disorders are available; however, these interventions are rarely routine in settings where most people receive services¹. Lack of community-based implementation of evidence-based treatments may be due, in part, to challenges faced by those seeking to implement treatments, such as selecting staff to train, buffering implementation efforts to withstand the negative impact of high staff turnover², maintaining treatment model fidelity, and maintaining administrative support³.

To enhance our understanding of mental health administrators' perspectives of opportunities and challenges in implementing an evidence based treatment (EBT), we conducted semi-structured interviews with administrators of community mental health agencies prior to and after completing an initiative to implement Dialectical Behavior Therapy (DBT) as part of a multi-county effort to improve the quality of behavioral health care provided to publicly-insured individuals in eastern Pennsylvania. To enhance our understanding of clinician experiences, self-report data were collected from clinicians at four time points, coordinating with the training timeline: pre-training (February 2007) as well as 6 months (August 2007), 14 months (April 2008), and 20 months (October 2008) after pre-training on constructs such as clinician knowledge, skill, satisfaction (with training and treatment), and DBT utilization.

Methods

Sample

Administrators. Administrators from all organizations participating in the DBT implementation were asked to participate in two interviews: one prior to and one after the implementation. Administrators ($N = 13$) from 9 of the 10 organizations participated in the first interview conducted in early 2007; the second interview will occur in early November 2008. Data will be ready by March 2009 for the Research Conference.

Clinicians. Fifty-nine of the 64 clinicians (92%) returned the initial survey. Across three of the four data points, survey return rates continued to be above 91%; the fourth and final data collection will be completed by November 30, 2008. Of those who returned completed surveys, 79% were female, 95% identified their race as being Caucasian, and 72% percent had obtained a Masters Degree or higher.

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Procedure. Using a mixed methods approach, semi-structured interview questions for administrators were developed based on a review of the literature and revised according to stakeholder suggestions. Clinicians completed a survey focused on clinician knowledge, skill, satisfaction, and DBT utilization.

Results

Using qualitative data methods and software, four major themes were identified within the administrator interviews: (1) staff selection and turnover's affect on implementation, (2) concern of sufficient client referrals, (3) DBT's general merit and concern about its fit with existing practices, and 4) concern about implementing DBT with existing organizational resources and reimbursement paradigms. Prior to training, 90% of clinicians thought that at least "some" change would need to be made to their current practice to implement DBT, with 41% reporting significant change would be necessary. Clinicians reported that they thought the DBT training initiative was important to agency administrators (73%); however, 48% reported little to no changes were made to their job duties to accommodate training including little to no decreases to productivity demands (60%) and little to no decreases to caseload demands (77%). Only 36% of clinicians reported having active cases appropriate for DBT. Results will highlight similarities and differences pre and post implementation as well as compare and contrast administrator versus clinician perspectives.

Conclusions

Challenges mentioned by agency administrators were most often related to resources (staff, financial). Clinicians reported increased confidence in and use of DBT over time; however, they continued to report that no changes were made to their jobs to accommodate training. The number of clinicians participating in training decreased over time; and some agencies experienced up to 67% staff turnover. Implications on EBT implementation for all of these issues will be discussed.

Experts have discussed clinicians' need for a "learning period" in which they take fewer clients and have their work time offset to enable them to prepare for consumer sessions and observe other clinicians implementing treatment^{4,5}, all of which is difficult from an administrative standpoint due to lost productivity and revenue, yet important from a clinician standpoint. Though precise numbers may be unavailable, rough estimates from treatment researchers regarding resources needed to implement a new intervention would allow administrators to make more informed choices, and permit administrators to better plan for implementing and sustaining the treatment.

Another consistent theme was the challenge of workforce instability coupled with fragile financial infrastructures. In the current fee-for-service environment, a typical response is to point to inadequate resources (e.g., reimbursement rates) and reliance on client volume. The impact of a labor intensive cost structure with substantial non-direct service costs (overhead) greatly complicates efforts to adopt new and improved practices. Our findings support the view that implementing and sustaining effective new treatments will require open dialogue with multiple stakeholders about financial “best practices” to fairly examine the ratios of overhead to direct care costs.

Participants also emphasized that EBTs are implemented in the context of an already complex, ongoing, clinical enterprise. Change at multiple levels including practitioner, team, organization and larger system is necessary to effect large-scale change in treatment delivery. EBTs need to be perceived by community-based mental health professionals as easy to implement and compatible with existing services⁶. Similarly, the intervention’s fit with an organization’s current service delivery structure, mission, interests, and resources influences its ease of implementation⁷.

Participants expressed concern that the treatment, while “ideal,” might not be realistic, being too time- and cost-intensive. Some have suggested a potential solution as implementing “active ingredients” or components within large models⁸. However, implementing DBT components, rather than the full model does not result in the same treatment benefit⁹. Another alternative may be to train clinicians in evidence based practices (e.g., evidence informed assessment, clinical decision making) rather than specific evidence based treatments. Such an approach has the potential of improving care for a broader base of consumers, as well as addressing administrators’ concerns about having insufficient consumers for any one approach.

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Tuesday, March 3 » 3:15 pm

Special Session D Room 8-10	Discussion—Best Practices for Mental Health in Child Welfare <i>Panel: Lisa Romanelli, Peter Pecora, Robert Hartman & Corvette Smith</i>	Page 174
Session 43 Salon A-B	Symposium—Conflict and Its Management in Systems of Care <i>Chair: Mary E. Evans</i> Results of a National Survey of Federally Funded Systems of Care <i>Mary E. Evans, Huey Jen Chen & Roger A. Boothroyd</i> Use of Concept Mapping to Understand Conflict Management in Systems of Care <i>Huey Jen Chen & Robyn Boustead</i> Talking About Conflict: Results from a Learning Collaborative <i>Sheryl Schrepf</i>	Page 174
Session 44 Salon C	Symposium—Improving Client Outcomes through Effective Implementation of EBPs: Provider Organizations' Perspectives <i>Chair: Jacquie Brown</i> <i>Discussant: Jim Wotring</i> Harmony in Duality: Using Evidence-Based Programs to Transform the Traditional Parts of Your Agency <i>Edward Myers Hayes & Josephine Emilio</i> The Implementation of Evidenced-Based Practice in a Children's System of Care: What Worked and What Didn't <i>Timothy Dunst</i> A Demonstration of Improving Client Outcomes as a Result of Effective Implementation Processes and Appropriate Evidence-Based Practices <i>Jacquie Brown & Matt Sheridan</i> Implementation of Evidence-Based Practices: An Evaluation of a Monumental Organizational Change Process <i>Melanie Barwick & Bruce Ferguson</i>	Page 178
Session 45 Salon D	Psychotropic Medication Utilization in Two Intensive Residential Programs <i>Ronald Thompson & Annette Griffith</i>	Page 181
	ROLES Revision Project: General Environment Types <i>Ronald Thompson & Peter Pecora</i>	Page 182
Session 46 Salon G	Community Defined Evidence: Research from the Ground Up <i>Linda Callejas & Ken Martinez</i>	Page 183
	Utilizing Family Workers in the Delivery of Mental Health Services for Families with Young Children <i>Joan Yengo</i>	Page 184
Session 47 Salon H	First Look: The Intergenerational Effects of Trauma on Child and Family Outcomes <i>Sarah Goan & Helaine Hornby</i>	Page 185
	Addressing Suicide Issues in Systems of Care Communities: How are Caregiver Strain and Youth Suicide Attempt Related? And How Can We Help Children and Families? <i>Crystal Barksdale & Sylvia Fisher</i>	Page 186
Session 48 Salon I	WFI for CQI - Measuring Change in Wraparound Fidelity after Implementing Improvement Efforts <i>Joan Kernan & Brian Pagkos</i>	Page 188
	Effects of Wraparound from a Meta-Analysis of Controlled Studies <i>Jesse Suter & Eric Bruns</i>	Page 189
Session 49 Salon J	Topical Discussion—Promoting Effective Behavioral Health Practices in a Statewide System of Care <i>Robert Franks, Jeffrey Vanderploeg, Jennifer Schroeder, Jason Lang, Samanta Matlin, & Jeana Bracey</i>	Page 191

Special Session D » 3:15 - 2:30 pm » Room 8-10

Discussion

Best Practices for Mental Health in Child Welfare

Panel: Lisa Romanelli, Peter Pecora, Robert Hartman & Corvette Smith

The 2007 Best Practices for Mental Health in Child Welfare Consensus Conference brought together experts in the fields of child welfare and mental health research, policy and services as well as parent and youth child welfare advocates to discuss the best ways to address the mental health needs of youth in the child welfare system. As a result of the conference, 32 guidelines covering the areas of mental health screening and assessment, psychosocial interventions, psychopharmacological interventions, parent support, and youth empowerment were developed. This discussion will provide a brief overview of the guidelines, their development, and rationale and discuss the implications of the guidelines from the perspective of child welfare agencies and families.

Session 43 » 3:15 - 4:15 » Salons A-B

symposium

Conflict and Its Management in Systems of Care

Chair: Mary E. Evans

This symposium presents a discussion of a project to examine the sources of conflict and methods of conflict management that are used in systems of care. It includes a report of a needs assessment that was conducted by requesting members of the governing board to respond by mail. It describes a concept mapping exercise conducted with several sites to learn about conflict management, and also presents findings from a learning community. Discussion will focus on learnings from this project for conflict management in systems of care.

Results of a National Survey of Federally Funded Systems of Care

Presenting: Mary E. Evans, Huey Jen Chen & Roger A. Boothroyd

Survey Method

We became aware of conflict as an issue in systems of care while conducting a study on collaboration. In order to understand the nature and sources of conflict and its management in systems of care, we conducted a mail needs assessment of federally-funded and graduated systems of care. Systems were not surveyed until they had been funded for at least one year. Needs assessment packets were sent to the director of the SOC with instructions to distribute copies to the members of the governing board. A self-addressed envelope was provided to permit respondents to return the completed questionnaire. Respondents could also complete the needs assessment online.

Results

We received a total of 301 responses from 59 of 111 sites surveyed. Sixty-seven percent of the respondents were female, the modal respondent was middle aged, and 67% were Caucasian with other respondents being African American, Hispanic, and Native American. Family members represented 18% of respondents, while those from the mental health system comprised 13%. Other respondents were representatives of other child serving systems and project directors.

More than 70% of respondents reported the existence of conflict in their system of care. The three most common sources were disagreements about goals (84%), difficult relationships (84%), and issues related to authority (80%). The most common ways of dealing with conflict were analyzing the problem and developing a strategy to deal with it (38%), dealing with the conflict behind the scenes (28%), and ignoring the conflict (27%). The techniques used to manage conflict included facilitation, negotiation, and mediation, although a minority of sites resorted to arbitration or the judicial system to resolve the conflict.

When asked to rate the effectiveness of the governing board, 52% of established sites rated the board as effective while 49% of newly established sites rated the board as effective. This was not statistically significant. However there were statistically significant differences between old and new sites on the meeting environment and dealing with board business with more established sites reporting more positive responses.

Regarding the effectiveness of the system of care, there was a significant difference in responses between parents and professionals ($p = .037$). Parents rated the effectiveness below 5 on a 7-point scale while professionals rated the effectiveness between 5 and 6 on a 7-point scale.

Findings have implications for the governing structure of systems of care at different points in their development, and suggestion directions for future research.

Use of Concept Mapping to Understand Conflict Management in Systems of Care

Presenting: Huey Jen Chen & Robyn Boustead

Introduction

Local systems of care were selected for site visits to reflect different stages of development and different experiences with conflict. Methods included concept mapping, interviews with key stakeholders, and document review. Concept mapping was used to identify organizational processes that support effective systems development including conflict management and prevention activities. Site visits were conducted by a researcher trained in concept mapping technology and two co-facilitators experienced with conflict and system of care.

Description

From the national needs assessment we found a high prevalence of conflict within systems of care. In order to understand how system partners handle conflicts, we used concept mapping in local systems at different stages of development and with different experiences with conflict. These sites engaged in a concept mapping exercise, and we conducted interviews with key stakeholders and document review.

Concept mapping is a mixed-methods approach that has been used for planning and evaluation (Greene & Caracelli, 1997; Kane & Trochim, 2007; Trochim, 1989; Trochim & Linton, 1986). Through the concept mapping process, the ideas of participants are translated into graphic or picture form through a focus group. Participants express their ideas or statements on a focus prompt through a group brainstorming session. All non-duplicated ideas or statements are sorted based on similarity and rated on level of importance. These statements are sorted and rated by participants. Data then are analyzed and the results are presented with visual representation.

The concept mapping exercise was conducted with the site's governing board and was used to identify organizational processes of conflict management and prevention activities that supported the system of care's ability to carry out its mission and goals. The prompt statement was, "When disagreements arise in our system of care, we...". Non-duplicated statements that were generated based on the focus prompt in the brainstorming session were sorted and rated on level of importance by members of the Governing Board. Using the concept mapping strategies with Concept System Software program, these sorted and rated statements were organized into clusters to illustrate: (1) the array of statements expressed; (2) how the statements are related to one another; (3) how the ideas can be organized or clustered into general concepts; and (4) how concepts are rated by the group in terms of importance.

Following the concept mapping exercise, individual key informant interviews were conducted with three members of the Council, each representing a different agency or a family perspective. Interviews were structured to explore perceptions of conflict within the system of care community, how members acknowledge and address conflict, and conflict management techniques utilized. Informants were also asked about the

Council's history. Specifically, they were asked to describe critical incidents involving conflict or the potential for conflict and how these incidents were resolved. A document review was used to identify protocols and formal processes that established norms for interaction including written dispute resolution protocols. Minutes of the Council's meetings for the last two years were examined for evidence of disagreement, whether or not a conflict was acknowledged, and whether or not the discussion moved the team closer to collaboration or conflict management.

Findings

The concept mapping process from one community that has been successfully dealing with conflict reveals five main factors (clusters), in order of importance, that contribute to one specific site's ability to function effectively. These factors are: (1) agency relationships and shared vision (4.40), (2) collaborative culture (4.32), (3) structure and infrastructure (4.21), and (4) problem-solving skills (3.89). Data from additional sites will be available before the conference.

Agency Relationships and Shared Vision. This cluster relates to understanding the perspectives of other agencies, focusing on shared values and philosophy, and maintaining mutual respect, civility, and positive relationships among individuals from different agencies. The items were clustered very tightly together and were rated as the most important of the five, suggesting that participants a similar view or concept of "agency relationships and shared vision." This finding is consistent with key informant interviews and document review.

Collaborative Culture. Items in this cluster reflect expectations for collaboration, leadership that prioritizes and models collaborative behavior, and a culture that actively embraces and teaches collaboration as part of people's jobs. During the concept mapping process, there were numerous statements reflecting a "long history" of collaboration and an organizational culture based on a non-negotiable expectation of cooperation for both staff and administrators. It was also noted that these values are regularly "passed on" to new personnel through formal training, staff supervision, and informal coaching and modeling of valued behaviors. As a result, people do not fear conflict but consider working with "differences between people" to be a routine part of their job.

Structure and Infrastructure. This cluster relates to structural arrangements that support collaboration, forums where issues can be brought for discussion and where core values can be brought to bear on specific situations, and agreed-upon procedures for council members to act with a collective voice. In the community, a number of structural accommodations have been made to support the successful resolution of conflict and to smooth the way for ongoing collaboration.

Respectful Communication. This cluster includes items that reflect good communication and conflict management skills and expectations that problems will be worked out between the individuals involved. Staff and administrators in the local community placed high value on clear and respectful communication at all levels of the system. Participants conveyed an understanding that clear and respectful communication can prevent conflicts as well as help to resolve them. Training on communication skills was widely available.

Problem-Solving Skills. This cluster is related to making good decisions, such as the use of data; proactive information sharing; bringing people together for participatory decision-making; and skills regarding the use of formal structures and the chain of command. Staff and families had a number of opportunities to receive training to develop new and enhanced problem-solving skills. Training was seen as essential, and the application of new skills was encouraged. Governing Board members were taught to recognize and work effectively with differences between people and positions.

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Talking About Conflict: Results from a Learning Collaborative

Presenting: Sheryl Schrepf

Contributing: Andrea K. Blanch

Introduction

Community coalitions and collaborations have become a defining feature of social services in the past decade. Coalitions are by nature more complex than organizations, and are full of paradoxes and conflicts that often mirror conflicts in the community. Transforming internal conflicts may therefore be key to addressing larger community issues. Research suggests that coalitions need to identify and recognize conflict among members, equalize relationships with powerful institutions, support norms that allow conflict to be raised and transformed, and provide assistance in resolving and transforming conflict. (Chavis, 2001) Each party must clarify up front what they bring to the table, and naturally conflicting goals and cultures must be identified and discussed (Linden, 2003). Furthermore, the process of developing collaboration is nonlinear and emerges as parties interact over time, and often has unanticipated outcomes—making it critical to allow the vision to unfold over time (Thomson & Perry, 2006).

Despite the importance of addressing differences, many coalitions appear to stress cooperation without developing clear guidelines for collaboration, internal communication systems that could foster problem discussion and resolution, or training in conflict management skills for individuals (Foster-Fishman, Berkowitz, Lounsbury & Allen, 2001). Few organizations or coalitions are skilled at discriminating between constructive conflict that encourages creativity and destructive conflict that damages relationships. In addition, few managers know how to create a safe environment for conflict to be identified and worked with, or how to support norms of "conflict appreciation," (Caudron, 2000). In their rush to "collaborate" many new coalitions assume that conflict is something to be avoided at all costs. As a result, real differences that could provide energy for change are denied or avoided, setting the stage for more serious problems to erupt later.

Background

The University of South Florida, under contract with Macro International, is conducting a five-year study to examine how conflict affects the development of systems of care. The study includes a national needs assessment, site visits, concept mapping, and the development of intervention tools. To date the study has shown that conflict is common across SOC sites and among all stakeholders; that many sites are reluctant to identify or address conflict; and that identifying and handling conflict appears to be related to success and sustainability.

Method

Two 2-hour “Learning Collaborative” conference calls were held in September and October, 2008. The calls were designed to gather input about conflict from key individuals at current and/or graduated sites and to assist in the development of intervention tools. Participants represented a variety of roles in systems of care, including current and former project directors, family members, a youth coordinator, technical assistance coordinators, trainers and researchers. The calls were moderated and recorded by members of the research team.

After introductions, a brief summary of the study was given, and two focus questions were posed: (1) During the development of your system of care, were there any points when you felt that your SOC was about to fall apart? What was going on at the time? and (2) What concrete mechanisms did you put in place (or would like to put in place?) to help you better prevent or handle conflict at your site? Dialogue and discussion among participants was encouraged. Results of the two calls were merged, key themes identified, and a summary was sent to all participants for review and feedback.

Results

Fourteen key themes emerged from the two calls, reflecting the impact of conflict on systems change, the development of family-driven and youth-guided systems of care, partnering and collaboration, and sustainability. The themes were as follows:

I. Systems Change

- Conflict is to be expected and welcomed in the development of SOC.
- The development of SOC is really about systems change, and should be guided by a theory of social change.
- The role and function of the project director is key. Project directors need training, coaching and support, with a focus on skills as a change agent.
- Time needs to be spent developing consensus not just on the vision but also on how the vision will be implemented and what barriers will be encountered.

II. Creating Family-Driven and Youth-Guided Systems

- Conflict between family members and others needs to be more carefully examined and understood
- Power imbalances between large and small agencies—particularly volunteer and family organizations—need to be addressed.

III. Partnering and Collaboration

- Address conflict styles from the start—conflict avoidance is a major part of the problem.
- The introduction of a neutral outsider trusted by all parties and specific tools to look at specific issues is helpful—better sooner than later.
- Spend more time on communication, going below the surface.
- Need to have specific provisions within the SOC for handling conflict.

IV. Sustainability

- Anticipate increased conflict as systems of care become successful.
- Conflict at the local level is not separable from conflict at the state and federal levels.
- Unexpected problems (whether internal or external) will be amplified by unacknowledged or unresolved conflict.
- Required strategic planning and budgeting processes could serve as a framework for addressing some of these issues.

Discussion

Preliminary data from the national needs assessment conducted as part of this research project suggested that systems of care, like most community coalitions, experience conflict between participating agencies and individuals, and often have trouble identifying, surfacing or responding proactively to this conflict. Qualitative results from the two “Learning Community” conference calls described in this presentation confirm this finding. Conflict appears to have an impact on four areas that are vital to the development of effective systems of care—systems change, the development of family-driven and youth-guided systems, partnering and collaboration, and sustainability. Fourteen themes emerged from the conference calls, reflecting the experience of participants in a variety of roles and in a number of different current and former sites. These results highlight specific ways in which conflict emerges in different phases of development of systems of care, and ways in which it impacts different stakeholders. Results also suggest concrete ways in which conflict could be identified and worked with to improve the functioning of systems of care. The next phase of the project will be to develop and test a series of intervention tools based on findings from the study.

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Session 44 » 3:15 - 4:15 pm » Salon C

symposium

Improving Client Outcomes through Effective Implementation of EBPs: Provider Organizations' Perspectives

Chair: Jacquie Brown

Discussant: James Wotring

Provider organizations face a number of challenges when implementing evidence-based practices and these challenges are magnified if multiple EBPs are implemented. Many organizations find they are not structured in a way that supports the effective implementation and sustainability of EBPs. Consequently, organizational change is an inevitable component for organizations to work through when implementing EBPs. Four organizations from New York State, Arizona and Ontario will illustrate how they have implemented and evaluated the implementation of evidence-based programs (EBPs). Each organization brings an unique experience to the implementation and delivery of EBPs with different goals, different funding sources and different structures. Two of the organizations are community based service providers offering multiple services, the third is a research organization which, through its activities, has contributed significantly to informing effective implementation processes. Each is at a different point in its role in implementation of EBPs. In some cases, implementation and evaluation have progressed sufficiently to the point that there is evidence of effective client outcomes. Implementation models and methods will be described, with attention to lessons learned for 'replication' in other provider organizations.

Harmony in Duality: Using Evidence-Based Programs to Transform the Traditional Parts of Your Agency

Cayuga Homes for Children

Presenting: Edward Myers Hayes & Josephine Emilio

Beginning as an orphanage in 1852, Cayuga Home for Children has changed to meet the changing needs of children and families. Since 2000, we have implemented twenty evidence-based programs throughout Central New York State and New York City. Specifically, we have successfully implemented multiple Functional Family Therapy, Multi-Dimensional Treatment Foster Care, and Multisystemic Therapy programs. This has resulted in our examining our more traditional programs. Initially, we faced conflict and competition between the new and the old—specifically as our traditional programs felt overshadowed and devalued by our emerging evidence-based work. The situation was summed up by one staff from a traditional treatment program who talked of “our evidence-based and our dinosaur programs.”

This discussion will outline how we transformed this emerging conflict into a cooperative environment where both types of programs can support and extend each other.

We will present practical techniques for transforming envy into cooperation, will share how our traditional programs helped our evidence based programs adapt to local conditions, and how our evidence based programs brought fidelity and rigor to our traditional programs.

Strategies include:

- Educating all staff about the principles of evidence-based treatment.
- Assisting our new staff in working with county and state customers on the workforce level—the people who make referrals or don't, who allow youth to stay in evidence based programs or revoke them to detention—so these customer bought in to evidence based practice, and

- Clearer definition of existing programs and the staff role and actions in these programs to ensure all staff were implementing the same program development of fidelity measures to maintain this.

Specifically, we will review a logic model we have created for all programs of:

- Defining a target population and target problem
- Developing a hypothesis of why the problem exists
- Developing an intervention aimed at this hypothesis
- Structuring and manualizing the intervention
- Developing methods to create fidelity regarding the delivery of the intervention
- Longitudinally measuring outcomes

Finally, we will present hybrid models under development. These models include FFT to reduce the length-of-stay in residential placement and determining when FFT or MST is most appropriate in community treatment. Regarding the first, we are piloting beginning FFT at the 16 to 18 week mark of Residential Treatment, so the youth and family have four to six FFT sessions prior to discharge at 20 to 24 weeks. The remainder of the FFT intervention is completed after discharge—as FFT serves both a transition and an after-care role for the youth and family. Regarding the second, we are exploring which presenting issues and characteristics most effectively pre-determine whether to use FFT or MST with a family. Factors include the number and complexity of presenting issues but also family intimacy preferences with MST being more appropriate for families which like close intimacy and FFT for families which prefer less intimacy.

The Implementation of Evidenced-Based Practice in a Children's System of Care: What Worked and What Didn't

Touchstone Behavioral Health

Presenting: Timothy Dunst

In 1999 Arizona was undergoing drastic changes in its system of delivering children's behavior healthcare. As the result of a law suit claiming inadequate Title XIX services, the system of care was radically changing from a traditional model to a child and family driven model. In this environment Touchstone Behavioral Health began implementing evidenced-based treatment. With four successful implementations and one failure, a sociological autopsy reveals what worked and what didn't.

In 1999 the Board of Directors of Touchstone mandated that all interventions must have proven outcomes. A decision was made to replicate evidence-based practices. Beginning with Functional Family Therapy, Touchstone began a process of introducing EBP to Arizona. At the same time the children's behavioral health system was experiencing sweeping changes. The environment was initially hostile, claiming that manualized evidence-based practices were too prescriptive and did not allow the child and family to determine the treatment process. Only the juvenile justice system supported our replication of Functional Family Therapy.

Touchstone slowly was able to change the belief system that did not accept EBP. Along with changing the external structure the agency was experiencing comprehensive organizational changes. With these stressors Touchstone successfully replicated Functional Family Therapy, Multisystemic Therapy, Brief Strategic Family Therapy, and Multisystemic Therapy-Problem Sexual Behavior and failed in its attempt to implement Multidimensional Treatment Foster Care.

Before implementing an EBP an organization should ensure that the practice under consideration meets its mission and the Board of Directors understands the commitment that is being made. With the support of the Board and an in-place champion of the practice under consideration, agencies can confront the external dynamics with which they must deal. These are the external factors that will support or undermine the success of the implementation. Problems involved licensing, contracting, referrals and the fit of the EBP within the existing system matrices. Other options will be discussed including conducting research on a new intervention that agencies have developed themselves.

A Demonstration of Improving Client Outcomes as a Result of Effective Implementation Processes and Appropriate Evidence-Based Practices

Kinark Child and Family Services, Ontario Canada–Direct Response
Presenting: Jacque Brown & Matt Sheridan

Introduction

To improve responsiveness and effectiveness on intake and triage, Kinark Child and Family Services has designed and implemented a new client response process. As a result of the initial implementation of this process, the waiting list at the front door has been reduced from over 400 to less than 140 in one year. In addition to a significant reduction in wait time, families who can benefit from one of two brief interventions are immediately engaged in service.

For many years Kinark Child and Family Services, a geographically dispersed, multi-service agency, sustained a waiting list of over 400 clients for children's mental health services, and a wait time after referral of up to 5 months for initial appointment. Upon analysis it was recognized that a differential response based on referral information could lead to a more effective response to clients, as well as a more effective use of resources.

Method

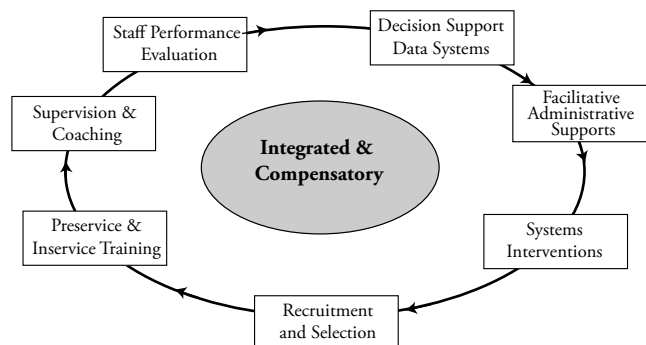
Using the Brief Child and Family Phone Interview data, Kinark examined the client characteristics, presenting issues and areas of symptomology in the clinical range at referral. These data demonstrated that approximately 30% of the client population could be treated with brief interventions. The new model would require new procedures, processes and EBPs. To develop a new model, Kinark applied the NIRN implementation model (Fixsen, Naoom, Blase, Friedman & Wallace 2005), to choose the treatment practices and design processes. The model guided the agency through the Exploration stage at which practices were chosen, and through the Installation phase at which a preliminary implementation plan was developed. This plan was further developed and executed during the Implementation stage. The process has led to the development of a cohesive intervention process supported by organizational structures and systems to ensure effectiveness. All aspects of the organization have been involved in the process.

The implementation model, specifically the use of the Implementation Drivers, (Fixsen, Naoom, Blasé, Friedman & Wallace 2005), facilitated effective change in the Kinark Client Information Data System (KIDS), training and supervision practices and client processes.

The seven implementation drivers refer to various organization functions and the Installation team addressed each of these areas in the implementation plan.

- **Human Resources**, including Recruitment and Selection, Pre-service training and In-service training; and Supervision and Coaching

Figure 1
Core Implementation Components



Fixsen, Blasé, Friedman, Wallace 2005. National Implementation Research Network.

- **Information Technology/Research Evaluation**, including Decision Support Data Systems and Facilitative Administrative Supports
- **Senior Management/Board**, addressing Systems Interventions

The Implementation Plan outlines specific actions and changes that need to occur in each area to ensure implementation of the practices and processes can be effectively achieved.

Results

Outcomes to date include a reduction in wait time for first appointment from 2 – 4 months to 2 weeks. The wait list in June 2007 was 459 clients; in December 2008 it was 108, with no reduction in referrals. Between April 08 and December 09 approximately 30% of the clients referred complete service within 60 days (approximately 300 clients) as a result of participation in one of the 2 EBPs. These clients could previously have waited for several months for assessment and potentially again for service.

Further outcome data will be available in the near future as the evaluation framework is applied and data is collected from clients and staff with respect to treatment outcomes, client satisfaction and the process.

Reference

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Implementation of Evidence-Based Practices: An Evaluation of a Monumental Organizational Change Process

Community Health System Resource Group, Hospital for Sick Children
Presenting: Melanie Barwick & Bruce Ferguson

The transition to full spectrum evidence-based clinical services at Kinark Child and Family Services provided a unique opportunity to conduct a process evaluation of evidence-based practices implementation and related organizational change. This is research in progress, using an organizational-level qualitative analysis of field notes, interviews, and brief questionnaires to describe the processes undertaken toward becoming a learning organization that is thoroughly structured to provide mental health services that are supported by scientific evidence.

Introduction

Kinark Child and Family Services is arguably the largest provider of child and youth mental health services in Ontario. Since the launch of the Ministry of Children and Youth Services' policy framework in 2007, policy makers and service providers have begun to consider how the elements of the policy framework will become actualized in the real-world system of care. Kinark's leadership has undertaken a decision to restructure all of its services such that all treatment provided is based on existing scientific evidence. This was a decision taken at the level of senior management for the organization. The research team undertakes this process evaluation with the understanding that knowledge learned through the evaluation will be shared with the Kinark management team over time, in order to shape the change process in an iterative, formative way. In addition, it is expected that this process evaluation will provide valuable knowledge for CYMH service providers and the Ministry.

Objectives

Using an organizational level analysis, the objective of this study is to describe the processes undertaken by Kinark Child and Family Services toward becoming a learning organization that is thoroughly structured according to the provision of child and youth mental health services that are supported by scientific evidence. This is a descriptive case study that aims to provide an analytical appreciation of the processes and changes that the organization will undergo over the course of a full year. The intended benefits of the study are to make a contribution to research in organizational change, and to inform the child and youth mental health field of the key lessons learned as a result of this change process.

Method

Design

This is a prospective single case study of process change in a single child and youth mental health service provider organization using mixed methods to capture elements of the change process over time (one year).

Process-based evaluations are geared to understanding how a program works—how it produces the results that it does. In this study, we seek to learn how a management-led decision to have all services be 'evidence-based' comes to fruition. We will document the management and organizational process that evolve over time, and capture staff members' perceptions and experiences of the change process over time.

Case Description

Kinark Child and Family Services employs 800 direct service professionals across four areas of service: Central East treatment program, Youth Justice and Secure Treatment, Autism, and the Kinark Outdoor Centre. In 2006-07, 4,364 children and youth were served in the Central East Treatment Programs, 535 in Youth Justice and Secure Treatment, 695 in Autism services, and 6,917 in their Outdoor Centre.

Qualitative Measures

Interviews. Two managers and two clinical staff per program and site will be interviewed from the list of staff who have consented to participate. It is anticipated that 32 staff interviews will be conducted.

Fieldnotes. A research assistant conducts non-participant observation and takes detailed field notes of the meeting process for several key meeting groups and to track two implementation teams through their processes.

Staff Perceptions and Knowledge of the Clinical Transformation Initiative. A staff questionnaire comprised of three open-ended questions is administered to staff on an annual basis. The questions are (Q1) What if anything, do you know about clinical transformation at Kinark? (Q2) How would you define evidence-based practice or treatment? (Q3) In your own work, do you use any courses of treatment considered to be evidence-based? These data are analyzed qualitatively.

Tracking of Milestones. A tracking log is kept and updated by the Kinark project manager (Rounthwaite) to document meetings, milestones, and goals.

Quantitative Measures

Organizational Learning. To capture the extent to which the organization demonstrates qualities characteristic of learning organization we are using the *Organizational Learning Survey* (Goh & Richards, 2007). The survey has 47 items of which 21 items capture learning organization attributes and dimensions, 6 items capture organization design and structure, 9 items focus on job satisfaction, and 8 items capture training and skill development practices. Scale reliability has been demonstrated at $\alpha = .90$. Validity of the scale was established through a predictive validity study (Goh & Richards, 1997) in which it was hypothesized that learning capability would be positively correlated with job satisfaction and negatively correlated with bureaucratic organizational structure. This was supported with 21 item scale correlated, $r = 0.66$ with job satisfaction and $r = -0.22$ with a measure of bureaucratization. Stability of the scale was also tested with a small number of business students (10 week gap between administrations) where a correlation of $r = 0.77$ was found, indicating the measure is stable over time. We expect that Kinark will demonstrate more characteristics of a learning organization over time (Fall 2007 to Fall 2008), as the transformation process and related activities transpire within the year of study.

Meeting Effectiveness. The Meeting Effectiveness Inventory is used to assess leadership, participation, decision-making, conflict resolution and productivity for the following working groups/meeting groups: (1) all Clinical Excellence Committee (CEC) meetings; (2) monthly Steering Committee meetings; and (3) the Provincial Management meeting but only for the portion of meeting dedicated to clinical transformation.

Results to Date

A baseline measure of the Organizational Learning Survey was conducted in 2008 with 272 staff members who endorsed many factors indicative of organizational learning. Some components or organizational learning were identified as needing intervention from management in order to effect change over time. These factors will be measured again in 2009.

Whereas in the fall of 2006, 25% of staff members had a basic understanding of the clinical transformation process being undertaken at Kinark, 50% of staff members could define "evidence-based practice," and 80% of staff could identify a Kinark program that was evidence based, questionnaire data from the fall of 2007 showed improvements across two of these markers, such that 53% of responders had an understanding of the clinical transformation process, 54% could define EBP, and 75% identified a Kinark program as evidence-based.

Reference

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Session 45 » 3:15 - 3:45 pm » Salon D

Psychotropic Medication Utilization in Two Intensive Residential Programs

Presenting: Ronald Thompson & Annette Griffith

Introduction

Medication rates in children and youth with behavioral disorders are high and controversial. The psychotropic medication rates of children and youth with behavioral disorders have greatly increased since the early 90's (Heflinger & Humphreys, 2008; Najjar et al., 2004). The norm is for youth entering residential treatment settings to be on one or more medication (Connor, Ozbayrak, Harrison, & Melloni, 1998), with the number of inpatient stays being a significant predictor of the total number of medications for a given youth (Zakriski, Wheeler, Burda, & Shields, 2005). Additionally, many medications prescribed are off label and pose significant health risks for children and youth with no efficacy data available to support their use (Zito, Craig, & Wanderling, 1994). The concern includes increasing rates of polypharmacy (Leo, 2006; Vitiello, 2005). High medication rates are predicted by medically indicated factors such as having a medication-appropriate disorder (e.g., ADHD, suicidality, psychotic diagnosis), but are also predicted by non-medically related factors such as race, state custody status, and private insurance (Hallfors, Fallon, & Watson, 1998; Zito, Safer, Zuckerman, Gardner, & Soeken, 2005). Optimal treatments for this population are both psychosocial and pharmacological, and take into account the broader ecology (Pappadopulos et al., 2006).

Methodology

This study examined medication rates for youth with serious behavioral disorders who entered either an intensive residential treatment center (IRTC) or a specialized treatment group home (STGH). Both these programs use a cognitive-behavioral treatment model with a strong medication management focus that emphasizes the minimum optimal medication level for each youth. The IRTC setting is a 24-hour residential treatment program for youth ages 7 to 18 with psychiatric disorders, and is a locked residential program specifically designed to offer medically directed care for more seriously troubled youth who require supervision, safety, and therapy but do not require inpatient psychiatric care. The STGH setting is a medically directed and secure residential treatment program for youth ages 10 to 18, with round-the-clock supervision within a more family-oriented environment for youth with psychiatric disorders.

Findings

This study examined the utilization of psychotropic medications and rate of aggressive behavior and restraints in these programs. Results showed overall a 35.8% reduction in the number of youth on medications from admission to discharge, going from 77.2% at admission to 51.3% at discharge in the IRTC and 71.2% at admission to 42.4% at discharge in the STGH. Similarly, there was a 40.1% reduction in the average number of medications per youth, going from an average of 3.4 medications at admission to 2.1 medications at discharge in the IRTC, and 3.2 medications at admission to 1.8 medications at discharge in the STGH. There was also a 51.8% overall decrease in the frequency of aggressive behavior, and a 69.4% overall decrease in the use restraints per youth during their stay in these programs.

Consistent with national data, youth come into these intensive residential treatment programs with high psychotropic medication rates. The reduction in medication rates along with reduced levels of aggression and restraint support the effectiveness of the combination of cognitive-behavioral treatment and careful medication management approach.

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Session 45 » 3:45 - 4:15 pm » Salon D

ROLES Revision Project: General Environment Types

Presenting: Ronald Thompson & Peter Pecora

Introduction

As early as the 1980s, researchers had concerns about how to measure environmental restrictiveness (Bachrach, 1980; Byalin, 1993). The Restrictiveness of Living Environment Scale (ROLES) was developed to meet this need and has served since 1992 as the primary way of conceptualizing the “restrictiveness” of a child’s living situation (Hawkins, Almeida, Fabry, & Reitz, 1992). It is a key performance dimension by many mental health, child welfare and juvenile justice agencies as an aid in helping children move to and function in less restrictive settings. However, changes in youth-serving systems have created a pressing need to revise the ROLES (Fields & Ogles, 2002; Handwerk, 2002). The ROLES ordered list of environments is neither mutually exclusive nor exhaustive, and the level of restrictiveness for any type of treatment setting varies widely going from program to program or youth to youth. The objective of this study was to revise the ROLES using an approach that would reduce the measure’s shortcomings while retaining its simplicity. Specifically, the goals of this study were to (1) create a conceptually-based reliable and valid measure that allows for precise measurement of environmental restrictiveness, and (2) provide an empirical basis for a simplified typology of restrictiveness that is intuitive and flexible.

As the objective of this effort was to base the ROLES revision on empirical data rather than relying on expert rankings of program types, our approach required a definition of restrictiveness and then the development of a measure for restriction on the basis of published literature. The conceptual definition used describes restrictiveness as “reflecting the ways in which adults in a child’s or youth’s life have anticipated the limits that need to be made for the child’s or youth’s safety, developmental, and therapeutic needs.” The Restrictiveness Evaluation Measure for Youth (REM-Y) was created based on this definition and includes items on activity restrictions (limits on what a person can do), movement restrictions (limits on where a person can go), social restrictions (limits on whom a person can see and spend time with), the burden of treatment (constraints embedded within treatment), and independent living (constraints placed on finances and living arrangements). These general areas were identified by reviewing the existing research and verified by researchers who have studied restrictiveness.

Methodology

The REM-Y and REM-S (a self-report version for older youth) were created using a process of expert review, cognitive interviewing, review by experts in culture, review by alumni of foster care and pilot testing (Huefner et al., 2007). The REM-Y or REM-S were emailed to over a thousand child organizations and to older youth, and completed on 595 youth. Rasch Measurement Model analysis allowed for description of the item and response option calibrations of the REM-Y/S, including the differential item function (DIF) across placement settings and across child and youth characteristics as well as the transformation of ordinal into interval data.

K-means cluster analysis was used to examine three-, four-, five-, and six-cluster solutions, and with the four-cluster solution producing the simplest solution with the most meaningful homogeneous groupings (Hair & Black, 2000). The four-cluster solution which translates to descriptive General Environment Types of “low,” “moderate,” “elevated,” and “high.” Low restriction environments have few or no limitations on what youth can do, where they can go in the community and environment, and who they can be with and for how long. Supervised

or unsupervised independent living, living with family or friends, and adoptive homes are typical of this cluster. Moderate restriction environments are ones in which there are a few limitations on what the youth can do. Parents’ home for young children, regular foster care, dormitories, and Job Corps are typical for this cluster.

Elevated restriction environments have more far reaching restrictions, such as time limits for communication and internet access, and interaction with friends. Treatment foster care, group homes, and less intensive residential treatment are typical of this cluster. High restriction environments have the greatest limitations on what the youth can do, where they can go in the community and environment, and who they can be with and for how long. Most residential treatment centers, wilderness camps, drug and alcohol rehabilitation facilities, youth correction/detention centers and emergency shelters are typical of this cluster.

Findings

The results also show that there is a degree of overlap among clusters; suggesting that when a more precise measure of restrictiveness is required, use of the REM-Y is warranted rather than simply using the General Environment Types.

Results support the creation of a conceptually based reliable and valid measure of restrictiveness that allows for greater accuracy in measuring environmental restrictiveness. The REM-Y provides very precise information about specific restrictions for a given child in an environment/program of interest. This precision should benefit child and adolescence behavioral health, welfare, juvenile justice research, such as linking living environment restrictions to program effectiveness.

The results also suggest that there are patterns of similarity and dissimilarity in the restrictiveness in the environments in which children and youth live, and that these patterns can be reflected in a simplified typology of restrictiveness. When the focus is limited to only environmental restrictions, treatment foster care and group homes do in fact have more in common and less that differentiates them than was presupposed in the original ROLES. Conversely, there is great variation in restrictiveness among residential treatment programs, with some having more in common with treatment foster care and others more in common with corrections programs. The General Environment Types are a simpler, more practical approach to environmental restrictiveness because the 25 levels of the ROLES, which were based on generalized assumptions about program types, have been reduced to four levels based on actual practice. The simplified structure is also more accurate in that differences in restrictiveness per se are not confused with other differences that exist between living environments and programs, such as cost or social desirability.

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Session 46 » 3:15 - 3:45 pm » Salon G

Community Defined Evidence: Research from the Ground Up

Presenting: Linda Callejas & Ken Martinez

Introduction

Disparities in mental health care for diverse populations are widening, especially as they relate to the accessibility, availability, quality, utilization, and outcomes of care. This national problem frequently results in misdiagnosis,¹⁻⁶ mistrust of public systems, and lack of adequate utilization of mental health services by diverse individuals and communities.⁷⁻¹⁰ Despite the dramatic growth of the Latino population in the U.S.¹¹ the mental health research literature related to Latinos reveals a number of similar gaps and issues of concern.^{12, 13}

The Community Defined Evidence Project (CDEP) was initiated in response to the growing concern for increased recognition and acceptance of community-based practices that may increase the use of behavioral health services^{14, 15} and/or result in improved outcomes, and the need to establish a means for documenting the positive effects related to such practices within Latino communities. The project aims to develop a systematic approach for identifying criteria that constitutes community defined evidence (CDE).¹⁶ The central goal of the Community Defined Evidence Project (CDEP) is to discover and develop a model for establishing an evidence base using cultural and/or community indices that identify successful community-defined and based practices. This paper presents preliminary findings on implementation of the CDEP to date.

Methodology

The CDEP is implementing a three-phased descriptive qualitative design to collect stakeholder input regarding community and/or culturally-based practices that are employed successfully in Latino communities. A national call for nominations was launched from July 2008 through September 2008 and identified a total of 56 organizations. These organizations provided a variety of services addressing a number of issues, including mental health, substance abuse, physical/medical health, and social services. They serve diverse communities of Latinos/Hispanics from various countries of origin, generations, and acculturation levels in 27 states and the District of Colombia.

Findings

The initial selection process for the study included completion of an initial screening interview to gather more information about community and/or culturally-based practices with a total of 42 sites identified from the larger pool of nominations, with an eye toward identifying 18 final study sites. Organization and program contacts who participated in interviews were also asked to submit documents that could provide additional information regarding the identified community-based practice(s). Interview responses and related documents were then reviewed to identify specific practices that were distinguished from more general approaches used to serve Latino/Hispanic communities, which were often described very loosely as "serving the community in a culturally competent manner" or addressing community concerns by upholding culture (described in a variety of ways). Examples of the types

of practices identified include:

- Practices that build capacity and raise consciousness among Latino/Hispanics (especially with regard to cultural and/or indigenous knowledge)
- Practices that raise public awareness about mental health
- Community outreach
- Innovative engagement practices
- Practices developed specifically to increase service accessibility
- Innovative interventions or therapies
- Local adaptations to evidence-based practices

After completing the review of screening interviews and the practices identified, a total of 37 practices were identified that were used specifically in the provision of behavioral health services for Latino/Hispanic populations. The remaining 37 practices were then assessed using criteria developed for reviewing practices identified and determine the degree of community use and support for a particular practice, the possibility for documenting its successful use in a systematic way, and the degree to which the use of a practice could be measured. These practices were reviewed then by CDEP Study Team members who assessed the degree of information provided in support of a practice (interviews and documents submitted as part of review, where available). Although a numeric rating was established for each item, a statistical measure for inter-rater reliability was not established and consensus was reached between raters following discussion of differing scores. An overall mean was calculated for each practice using the recoded scores. The 18 practices identified for additional investigation in Year 2 of the CDEP were those that received the highest mean score.

Data collection with the 18 study sites will be conducted from March through June of 2009 to gather additional information regarding the specific practice identified within each. Six of these sites will be asked to participate in site visits, and 12 sites will be asked to participate via telephone interviews. Each site will be asked to participate in a total of 20 interviews with participation from each of the following groups: agency administrators, supervisors, direct service personnel, paraprofessionals, community partners, current service users, former service users, and family members. Analysis will focus on documenting the common and unique characteristics among practices and define the "essential elements" of practices.

Conclusion

The Community Defined Evidence Project offers an important and exciting opportunity to advance the current body of knowledge on community-based practices "that work" for Latino populations. By developing an evidence base that uses cultural and/or community indices, we hope to influence the research and evaluation agenda, as well as policymakers and funding agencies, to implement and use innovative community-based practices to reduce disparities and improve availability, quality, and outcomes of behavioral health care for all individuals and families.

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Session 46 » 3:45 - 4:15 pm » Salon G

Utilizing Family Workers in the Delivery of Mental Health Services for Families with Young Children

Presenting: Joan Yengo

Introduction

The Mary's Center for Maternal and Child Care, Inc. is the lead agency for the Healthy Families District of Columbia (HFDC) program. It is a community health center that primarily serves DC's large and growing Latino population. HFDC is a home visiting program that uses a strength based approach to provide culturally competent, family centered services to at risk families with young children, with the ultimate goal of ensuring that children are healthy, safe, and ready for school. While HFDC has continually demonstrated success in meeting the needs of high risk families, the program also documented outstanding needs for mental health and other behavioral health services that extended beyond the core services of the program.

This paper presents data from a grant the Mary's Center received under the Starting Early Starting Smart (SESS) initiative funded by SAMHSA and Casey Family Programs to enhance mental health and substance abuse services for families participating in the HFDC program in DC. The program and evaluation were conducted between 2001 and 2005.

Methodology

SESS enhanced services

The HFDC/SESS project utilized a two-pronged approach that included both capacity building and program enhancement. Capacity building focused on strengthening the linkages between HFDC and community-based providers. Through developing new and innovative partnerships, HFDC could gain increased access to care, and better facilitation of referrals for families. Program enhancement focused on increasing staff availability and expertise to address needs in three key areas:

Mental Health. A bilingual mental health professional and increased time of an English-speaking mental health professional to conduct home visits and assess for mental health needs, link families with community resources that address ongoing needs, provide brief interventions as needed (particularly as a mechanism for facilitating longer term referrals), and track utilization of community services to demonstrate improved access to care.

Substance Abuse. A certified substance abuse counselor to conduct home visits with families at risk or with identified substance abuse

issues, refer to community agencies, and track utilization of community services. In addition, all HFDC staff would receive training on issues related to substance use and abuse, including recognizing signs of drug/alcohol abuse, and understanding the consequences of exposure to drug trafficking in the home, family and community.

Child Development. Two bilingual child development specialists devoted increased time to supporting families whose children have potential or identified developmental delays. In addition, HFDC worked on developing new activities for families aimed at promoting school readiness.

Target Population

HFDC/SESS targeted parents living in DC who were identified as being at risk for child abuse and neglect. All participants enrolled prenatally or within 30 days of birth of the target child. Referral sites throughout the District screened potential families. The screen was designed to identify risk factors such as domestic violence, history of child abuse, and self-sufficiency limitations that might lead to poor child and family outcomes. Families who were assessed as “Positive” were considered to be at moderate to high risk for abuse and neglect and are eligible for referral to the Healthy Families program. No additional exclusionary criteria were used for program participation. A total of 162 program participants and 56 comparison group participants were included in the evaluation.

Throughout the course of the SESS program, outcome measures were collected on both program and comparison group families. Initial measures were administered at enrollment (Baseline), and then re-administered after 6 months of participation, at 12 months, and annually thereafter. Due to attrition, the number of follow-up measures decreased with each subsequent administration, with very few measures being collected after 24 months.

Data were collected by trained program staff, evaluation staff, and trained research assistants. Bilingual staff were used for most of the program group and all of the comparison group data collection. In addition to outcome data tools, the evaluation also utilized process evaluation methods to document the evolution of the program and its implementation, and to provide feedback to administrators to effect program refinements. Both quantitative and qualitative data were collected on services rendered (including dosage data) in order to assess the program's effectiveness. Staff and parent satisfaction data provide an important supplement to outcome data tools in determining whether the SESS enhancements were effective in improving the well-being of families.

Findings

The impact of the mental health component was evident in the significant reductions in risk for depression (CESD scores) over the course of program implementation. Reductions in risk for depression were significant after just six months of program services for SESS participants.

The critical role of cultural and linguistic competence was evident in the implementation of the counseling component. Initially, the Spanish-speaking families were not easily engaged by the English-speaking counselor and the African American participants were equally unresponsive to the bilingual mental health provider. Clearly, cultural representation and competence were key variables in engaging families for mental health services. This is especially important when services are offered in the family's home. Participants regularly reported feeling more knowledgeable about such areas as parenting, assessing the needs of their children, coping with stress, setting and achieving goals, and accessing community resources.

Conclusions

Five key factors contributed to the success of the integrated model implemented by the HFDC/SESS program: (1) The program was implemented within a strong lead agency, the Mary's Center, which provides support and agency resources, endorses and promotes the program, and links program families to the agency's other services; (2) The strength of the core comprehensive services and existing program infrastructure of HFDC, which facilitated the successful outcomes in the areas of parenting, maternal and child health and child development, and which eased the integration of the mental health and substance abuse specialists and enhanced services into the program; (3) The responsiveness of the program to ongoing staff and evaluation feedback regarding the effectiveness of program components and the specialists. It was precisely this feedback that identified the outstanding and ongoing family issues with substance abuse and depression and resulted in the SESS enhanced model; (4) The availability of a culturally competent and bilingual Mental Health Specialist made it possible to engage the large Spanish-speaking population for behavioral health screening and services, and; (5) The training and consultation the Mental Health and Child Development Specialists provided to the Family Support Workers extended the reach of the professional services and built capacity within the program to increase the identification and referral of families for mental health and/or substance services, as well as developmental interventions.

Session 47 » 3:15 - 3:45 pm » Salon H

First Look: The Intergenerational Effects of Trauma on Child and Family Outcomes

Presenting: Sarah Goan & Helaine Hornby

Introduction

Maine's THRIVE System of Care (SOC) is the first system of care for children, youth and families with a specific focus on trauma-informed practices and services at every level. This integration of trauma-informed principles and practices within a system of care context makes THRIVE unique among system of care communities.

The trauma-informed approach moves away from a focus on correcting deficits and problem behaviors and instead views challenging behaviors as adaptive coping strategies that have been adopted to deal with difficult and overwhelming circumstances. Put another way, the core concept underlying the trauma-informed approach is not “What is wrong with this child and family?” but rather “What has happened to this child

and family?” This simple yet transformational shift in perspective forms the foundation for the trauma-informed approach.

The development of trauma-informed service approaches is supported by a growing body of research that documents the pervasiveness of trauma among children and youth and has linked trauma to a number of mental, emotional, physical health and social consequences. Trauma exposure has been associated with increases in health risk behaviors, higher rates of revictimization, higher use of restrictive and costly service alternatives, and poorer outcomes for children and youth. Less often studied is how the trauma experiences of the primary caregiver of these children may impact those children's outcomes.

The focus of this study is threefold: first, what is the prevalence of traumatic experiences in children and youth who are enrolled in THRIVE; second, what is the prevalence of traumatic experiences

among the primary caregivers of those children; and third, how are child and family outcomes affected by the family's history of trauma. The preliminary results present a compelling case for the need for developing, testing, and implementing trauma-informed service delivery approaches within systems of care for children, youth and families.

Methodology

After a review of 55 trauma tools from the perspectives of clinical efficacy and ease of administration by THRIVE evaluators, project staff, consultants and the Evaluation Committee, three were selected for use in this study. These tools are the Traumatic Events Screening Instrument (TESI), the Lifetime Incidence of Traumatic Events (LITE; both parent and child versions), and the Trauma Symptom Checklist (TSC; versions for Young Children and for Youth).

The trauma tools are administered to families and youth enrolled in the Longitudinal Evaluation within 30 days of intake into the system, and then again every 6 months in accordance with the National System of Care Evaluation Protocol. The primary caregivers are asked for their own trauma histories at the baseline interview. For children 11 and under, caregivers also provide the trauma history and symptoms. Children and youth over age 11 are asked about their trauma experiences and symptoms directly.

Data are currently analyzed using simple frequency and correlational techniques. However, new data are being collected continuously. The results from a larger sample will be presented, along with correlational relationships and tests of statistical significance. Trauma data will be linked to the data collected as part of the National Evaluation to determine the relationship between caregiver trauma experiences and child and family outcomes. These outcomes include standardized scores on the Child Behavior Checklist (CBCL) and Behavioral and Emotional Rating Scale (BERS), as well as stability of housing, school placements and family dynamics. Changes in the scores on the Trauma Symptom Checklist (TSC) between the baseline interview and six-month follow-up interview will also be examined to see if significant differences exist. The extent to which the number of adverse events/traumatic experiences reported by youth and families contribute to the likelihood of developing PTSD symptoms and potentially poorer outcomes will also be explored.

Preliminary Findings

The study population is constantly growing; to date, the data represent 52 children who are enrolled in THRIVE and their primary caregiver. The children and youth range from age 2 to age 20, with an average age of 11. Attentional disorders (ADHD) are the most common primary diagnosis (37%), followed by Mood disorders (14%); 8% have a PTSD diagnosis and 8% have Anxiety disorders.

Preliminary analysis shows that the prevalence of trauma experiences among participants enrolled in THRIVE is high. On average, youth report they have been exposed to 5 traumatic events and the caregivers report being exposed to an average of 7 traumatic events. Almost half of children and youth (48%) have witnessed domestic violence and 40% have been physically abused or threatened. More than three-fourths (78%) of caregivers reported being emotionally abused, and 64% have been threatened with death or badly injured. Among younger children, 45% (14) fall within the clinical range for anger/aggression, 39% (12) for depression, and 29% (9) for both PTSD and sexual concerns (meaning sexual behaviors, knowledge or fears that are not typical for the child's age). Among older youth, 40% reported trauma symptoms that were above the clinical range on at least one indicator.

In addition, preliminary correlational analysis shows a potential relationship between the number of trauma events experienced by a caregiver and the trauma that children are experiencing. For example, of those children enrolled in the study who had experienced 5 or more traumatic events, 96% lived with a caregiver who also experienced 5 or more traumatic events.

Discussion/Conclusions

These preliminary results indicate that the majority of children and families enrolled in THRIVE SOC have experienced significant amounts of trauma. An increased sample and additional analysis will help determine the extent to which trauma is significantly influencing child and family outcomes. Nonetheless, the preliminary results suggest that future SOC development should be closely aligned with the trauma-informed approach in order to best meet the needs of the service population.

Session 47 » 3:45 - 4:15 pm » Salon H

Addressing Suicide Issues in Systems of Care Communities:

How are Caregiver Strain and Youth Suicide Attempt Related? And How Can We Help Children and Families?

Presenting: Crystal Barksdale & Sylvia Fisher

Contributing: Christine Walrath, Jill Compton & David Goldston

Introduction

Suicide is currently the third leading cause of death in youth aged 10 to 19 (Centers for Disease Control and Prevention [CDC], 2008a). Additionally, over 90 percent of children and adolescents who commit suicide have a mental disorder. The Substance Abuse and Mental Health Services Administration (SAMHSA) has released data indicating that approximately 900,000 youth had made a plan to commit suicide during their worst or most recent episode of major depression; 712,000 attempted suicides during such an episode (SAMHSA, 2005). Over 7 percent of youth—1.8 million youth—indicated they had thought about killing themselves during their worst or most recent episode of major depression. Unfortunately, many teens do not disclose their depression or suicidal ideation and do not seek help for their problems. This high

degree of prevalence is a public health issue necessitating a coordinated response, grounded in a public health model, be applied to address these needs. Over the last 25 years, a system of care approach to the delivery of services for children with serious emotional disturbance and their families, has become common with multiple and consistent federal investments in their development and implementation (Pires, 2002). In order to identify and help prevent suicides among systems of care (SOC) youth, useful and appropriate protocols must be instituted at various levels. These protocols should also serve to facilitate the identification of early risk indicators of suicidal behavior and trends within these groups.

Several studies have examined the prevalence, incidence and nature of suicidal ideation and suicide-related behaviors and outcomes in a population of children and youth participating in systems of care (Mandell, Walrath & Goldston, 2006; Walrath et al., 2001). These studies indicate that approximately 25% of children and youth entering systems of care have a lifetime history of suicide attempt, with

approximately 8% having repeat attempts. Furthermore, these study findings suggest that subgroups of suicide attempters—based on attempt recency and frequency—enter service with different levels of functional challenge, and continue to experience these functional challenges differently at 6 months into service (Mandell, Walrath & Goldston, 2006; Walrath et al., 2001).

This presentation includes recent information on the prevalence of suicidal behavior among youth entering SOC, and describes important study results examining relationships between caregiver strain and youth suicide attempts. Results focus on understanding the degree and type of strain experienced by caregivers with a child who had attempted suicide and examines relationships between youth suicidal behavior, caregiver strain, general family functioning, and youth functional impairment.

Methods

The suicidal behavior sample was drawn from the outcome study sample of the national evaluation of SOC communities funded by CMHS between 2002 and 2004 and includes children at intake and 6 months into service with available data on their suicidal thoughts and behaviors. The caregiver strain sample includes a subset of 1,854 children and families with complete data on child age, gender, race, suicide attempt; caregiver gender, age, and relation to the child; family income; two family measures—the Caregiver Strain Questionnaire (CGSQ, Brannan, Heflinger, & Bickman, 1997), the Family Life Questionnaire (FLQ, developed for the national evaluation), and the Columbia Impairment Scale (CIS, Bird et al., 1993).

Results

Children enter systems of care with recent histories of suicidal behavior including, but not limited to, over one-quarter with a history of ideation in the 6 months prior to service entry; approximately nine percent having attempted suicide in that prior 6 month period. Furthermore, children continue to express suicidal thoughts and behaviors after entry into services, with nearly 20% experiencing suicidal ideation and approximately 5% attempting suicide during their first 6 months of service.

Children in the caregiver strain sample were predominantly White and male and averaged approximately 12 years of age. Nearly 15% of children had a suicide attempt history with a higher proportion of children 16 and older having prior suicide attempts. Caregivers for the children were largely female biological parents.

The results indicate that caregivers of suicidal and non-suicidal youth differed in subjective internalizing strain (e.g., worry and guilt), and objective strain (e.g., constraints on activities). These differences in objective strain persisted even after controlling for family life and youth functional impairment.

Study results indicate there is a significant association between youth suicide attempts with objective strain among caregivers, particularly among caregivers of youth with a history of any or multiple suicide attempts. This set of strains is particularly placed on the caregiver's personal time, work time, and finances. Perceptions of family life and reports of youth functional impairment were also related to strain, but differed as a function of youth suicidal behavior. Another major finding is that, in addition to the demands related to objective strain, both caregivers of youth with one suicide attempt and caregivers of youth with multiple suicide attempts were found to experience higher levels of worry, guilt, and fatigue (subjective internalizing strain) in both unadjusted models and models adjusted for family life and youth functional impairment.

Despite the significant emotional, physical, and financial demands (objective strain) reported by caregivers of suicidal youth, no differences were obtained among caregivers with regard to the levels of anger, resentment, or embarrassment (subjective externalizing strain) in the model that was unadjusted for family life and youth functional impairment. After adjusting for differences in these variables, the results show that the reported subjective externalizing burden experienced by caregivers of youth who have made multiple attempts actually appeared to be lower than that of other caregivers. This finding may be attributable to the strong relationship between externalizing strain and the covariates of family life and youth impairment; this would parallel previous research findings indicating that anger is not experienced as often as feelings of caring and sadness by parents immediately following youth suicide attempts.

Discussion

The service and family life implications of the caregiver strain related findings will be discussed including the importance of caregiver health and well-being as it relates to their own ability to actively and effectively contribute to the continued well-being and service planning for their children. Additional discussion with session participants will outline recent SOC program activities undertaken to address suicide in systems of care communities including the development of a policy statement and a logic model addressing suicide issues in the areas of suicide prevention, intervention, and postvention. Participants will be apprised of an upcoming May, 2009 meeting emphasizing the development of a detailed plan incorporating specific suicide prevention, intervention and postvention approaches and strategies to be applied within SOC communities to address suicide issues in systems of care communities.

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Session 48 » 3:15 - 3:45 pm » Salon I

WFI for CQI - Measuring Change in Wraparound Fidelity after Implementing Improvement Efforts

Presenting: Joan Kernan & Brian Pagkos

Introduction

Wraparound is a care management planning process that results in a unique set of community services and natural supports that are individualized for a child and family to achieve a positive set of outcomes (Walker et al., 2004). Family Voices Network of Erie County (FVN) began implementing the wraparound process and care coordination in 2005, and as a quality improvement process, FVN incorporated the Wraparound Fidelity Index Version 4.0 (WFI-4) to measure adherence to wraparound principles of care coordination.

Results from the 2007 WFI-4 study were reported to system administrators in the fall of 2007 and showed undesirable scores in fidelity for the transition phase of wraparound. This sparked development of case transition training and education programs for care coordinators, and mandatory transition planning in monthly family team meetings. Results were disseminated to a group of families and youth who made suggestions for improvements to the system of care. An orientation workshop, with a discussion about the wraparound process and transition, was also added for newly enrolled families. The research team recently completed the WFI-4 from 2008 to determine the magnitude of change in fidelity scores from 2007 to 2008. Presenters will discuss the findings from the 2008 analysis, compare WFI-4 scores for FVN in 2007 to scores in 2008, and conclude with suggestions for quality improvement.

Method

Participants

Sampling strategy. A convenience sample of qualifying families was taken in the summer of 2007 and 2008. Families were contacted via phone and asked to participate in the WFI-4 interview if they were receiving wraparound services for a length of time between three and 14 months. Parent, caregiver, and youth participation was voluntary.

Sample from 2007. Study participants included youth ($N = 33$, mean age = 13.5 years, 61.9% Male, 54.8% White, 25% Black or African American, 15.2% Hispanic, 5% Other), caregivers ($N = 105$), and case specific interviews with care coordinators ($N = 105$ interviews with 31 care coordinators). At the time of the interview, the average length of stay in the wraparound program for participants was 7.7 months ($M = 7.7$, $SD = 5.3$).

Sample from 2008. Study participants included youth ($N = 22$, mean age = 14.4 years, 69.2% Male, 58.9% White, 21.5% Black or African American, 12.1% Hispanic, 7.5% Other), caregivers ($N = 107$), and case specific interviews with care coordinators ($N = 107$ interviews with 48 care coordinators). At the time of the interview, the average length of stay in the wraparound program for participants was 7.5 months ($SD = 2.6$).

Materials

The WFI-4 is a structured interview that measures adherence to the principles and primary activities of the wraparound process on an individual child, youth or family basis. The WFI-4 is a conversational interview tool that assesses adherence to the ten principles of wraparound. The principles are organized according to the four phases of the wraparound process which include engagement, plan development, plan implementation and transition. The interview consists of 40 items for both the caregiver and care coordinator versions and 32 items in the youth version.

Findings from the initial WFI-4 pilot showed good internal consistency for total scores for all respondent forms and good internal consistency for most phase scores. Internal consistency in 2008 as measured by Cronbach's alpha shows that the WFI-4 item summaries by respondent were acceptable ($\alpha = .726$ for the wraparound facilitator form, $\alpha = .883$ for the caregiver form, and $\alpha = .872$ for the youth form).

Design and Procedure

Interviews. Family members, who at one time received wraparound services, were hired and trained to conduct the interviews. If the caregiver agreed to be interviewed, permission was requested to also interview the youth and, if obtained, the youth was interviewed. Once the caregiver and/or youth interviews were completed, the care coordinator assigned to the family was interviewed by phone.

Scoring. Responses resulted in two types of data, both respondent and case specific. Each respondent received a total score ranging from zero (low adherence to wraparound philosophy) to 2 (high fidelity to wraparound philosophy), and a subscale score for each phase of wraparound. Each case received an overall fidelity score, which was calculated by combining the scores of the three case-related respondents (care coordinator, caregiver, and youth).

Design. A cross-sectional design was used at both time points. The primary outcome indicators for this study included WFI-4 total and subscale scores by respondent group.

Results

Total scores. FVN combined total score improved from 81% in 2007 to 85% in 2008 (85% is considered high fidelity), $t(105, 107) = -3.314$, $p < .01$. Caregiver scores improved from 76% to 81% $t(105, 107) = -2.440$, $p < .05$, care coordinator scores improved from 88% to 91%, $t(105, 107) = -2.793$, $p < .01$, and although youth scores improved from 73% to 77%, the independent samples t test was not significant.

Transition scores. Caregiver scores improved from 63% in 2007 to 70% in 2008, $t(104, 107) = -2.228$, $p < .05$, care coordinator scores improved from 81% to 86%, $t(105, 107) = -2.340$, $p < .05$, and again, although youth scores improved from 62% to 67%, the independent samples t test was not significant.

Discussion

The transition phase, targeted for system improvement following the 2007 study, had improved scores for all respondent types and also had the largest improvements in scores when compared to the other phases of wraparound. However, both caregiver and youth scores for 2008, 70% and 67% respectively, are considered borderline fidelity. Low scores and sample sizes for youth signify the need to improve youth engagement in the wraparound process. A group of family members, youth, administrators, and care coordinators will be formed to brainstorm solutions to this deficit.

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Session 48 » 3:45 - 4:15 pm » Salon I

Effects of Wraparound from a Meta-Analysis of Controlled Studies

Presenting: Jesse Suter & Eric Bruns

Introduction

Recently there have been calls to better integrate evidence based treatments (EBTs) and systems of care. Wraparound has been recognized as a process through which EBTs could be implemented more widely and in ways that are consistent with system of care principles (Tolan & Dodge, 2005; Weisz, Sandler, Durlak, & Anton, 2006). One hope is that this integration would be more effective than implementing either approach alone.

Wraparound is a team based, collaborative process for developing and implementing individualized care plans for youth with complex needs and their families (Bruns & Walker, 2008; Burchard, Bruns, & Burchard, 2002). Wraparound has achieved widespread adoption across the U.S. and internationally, however its implementation must be clearly specified and its own evidence base must be developed before such integration could be reliable and effective. Wraparound's evidence base has lagged far behind EBTs. Previous narrative reviews of wraparound summarized findings across a wide range of studies, methodological designs, settings, and populations (Burchard et al., 2002; Burns, Goldman, Faw, & Burchard, 1999; Farmer, Dorsey, & Mustillo, 2004; Suter & Bruns, 2008). In general, they agreed that wraparound demonstrated a promising evidence base but clear conclusions were hampered by variability in wraparound implementation, methodology, and the significance of outcomes. The current study asked a more targeted question: When youth receiving wraparound are directly compared to youth in control groups, who receives more positive outcomes? Meta-analysis was used to answer this question by quantifying and summarizing the magnitude of effects across eligible studies and specific outcome domains.

Methodology

Selection Criteria

Studies were chosen for this meta-analysis that provided direct comparisons on outcomes for severely emotionally and behaviorally disturbed youth (SEBD) receiving wraparound to those in a control group. Both experimental and quasi-experimental controlled outcome studies were included to capture the best available evidence on wraparound. Other types of study design (e.g., single group, pretest-posttest studies) were not included.

Literature Search and Coding

A literature search yielded seven controlled outcome studies of wraparound that met selection criteria (Bickman, Smith, Lambert, & Andrade, 2003; Bruns, Rast, Peterson, Walker, & Bosworth, 2006; Carney & Buttell, 2003; Clark et al., 1998; Evans, Armstrong, Kuppinger, Huz, & McNulty, 1998; Hyde, Burchard, & Woodworth, 1996; Pullmann et al., 2006). The authors reviewed the seven studies and assigned codes to specific study, intervention, and outcome variables to permit comparisons across studies. The authors also coded the individual outcome measures for each study into four outcome domains: (1) living situation; (2) mental health outcomes; (3) youth functioning (which was further divided into the sub-domains of school functioning and juvenile justice related outcomes); and (4) assets and resiliency (however insufficient outcome data did not permit analysis of this domain).

Effect sizes were calculated or estimated for each outcome measured, then averaged to create a single mean effect size for each outcome domain and an overall mean effect size for each study. Two studies did not present their findings in a way permitting calculation or estimation of effects (Bickman et al., 2003; Evans et al., 1998), so effect sizes had to be

imputed. Reports of significant differences were considered to have $p = .05$ (permitting a conservative estimation of the effect size) and measures with no significant difference were considered to have an effect of 0.00. Effect sizes are typically interpreted following Cohen's (1988) conventions of small (0.20), medium (0.50), and large (0.80) effects.

Findings

Participants

The seven studies included a total of 802 children and adolescents ($M = 114.57$, $SD = 52.57$). Sample sizes for individual studies ranged from 42 (Evans et al., 1998) to 204 (Pullman et al., 2006). The mean percentage of females was 33.57% ($SD = 12.94$, range 10 to 49), and the mean age of participants was 13.43 years ($SD = 2.95$, range 9.0 to 17.3). On average, study participants were most commonly identified as Caucasian 56.95% and African American 23.10%. Lead agencies varied across studies including child welfare ($n = 2$), juvenile justice ($n = 2$), and mental health ($n = 3$).

Study Outcomes

The mean effect size across the seven studies was 0.33, falling between the conventional cutoffs for small and medium effects (see Table 1). Assuming a normal distribution of outcomes, the average youth receiving wraparound was better off than 63% of those receiving conventional services. The outcome domain *living situation* showed the highest mean effect size (0.44). Smaller effects were found for *mental health outcomes* (0.31) and *overall youth functioning* (0.25). Similar results were found for the functioning sub-domains of *school functioning* (0.27) and *juvenile justice related outcomes* (0.21).

Table 1
Summary of Overall and Domain Specific Effect Sizes

Outcome Domain	ES M	95% CI	Studies Involved
Overall effect size	0.33*	0.14 – 0.52	1, 2, 3, 4, 5, 6, 7
Living situation	0.42*	0.05 – 0.78	1, 3, 7
Mental health	0.24*	0.07 – 0.41	1, 3, 4, 7
Youth functioning	0.25*	0.04 – 0.45	1, 2, 3, 4, 6, 7
School functioning	0.24*	0.08 – 0.40	1, 2, 3, 7
Juvenile Justice	0.22*	0.02 – 0.42	1, 2, 3, 6, 7
Assets and resiliency	0.00		1 & 4

Note: Study numbers refer to: 1 = Bickman et al., 2003; 2 = Carney et al., 2003; 3 = Clark et al., 1998; 4 = Evans et al., 1998; 5 = Hyde et al., 1996; 6 = Pullman et al., 2006; and 7 = Rast et al., 2008
CI = confidence interval; ES = effect size; * $p < .05$

Conclusion

Overall the results of this meta-analysis support the view that wraparound can yield better outcomes for youth with SEBD when directly compared to youth receiving conventional services. The small to medium overall effect found in this review was similar to the mean effect from a meta-analysis of experimental studies directly comparing EBTs versus "usual clinical care" (Weisz, Jensen-Doss, & Hawley, 2006). Another key finding from this meta-analysis is that wraparound showed medium effects for measures of the youth living situation and smaller effects on measures of mental health outcomes and youth functioning (including school functioning and juvenile justice related outcomes).

There are several important limitations to note. First, only seven studies met criteria for this meta-analysis, which greatly reduces confidence in our conclusions that we have evaluated a representative sample of wraparound programs. Second, despite limiting the focus to controlled studies, several methodological concerns were reported (e.g., attrition, limited use of validated measures). We also did not have sufficient information to conclude that all programs in this review represented high-quality wraparound implementation.

Given these limitations, the findings point toward several recommendations. Perhaps one of the clearest messages is that more evaluations of high-quality wraparound programs should be initiated. This review provides the most systematic evidence base to date for the wraparound process. To truly test the evidence base of wraparound, studies must include implementation and fidelity data to support that wraparound was delivered. Similarly, future outcomes studies should utilize the strongest methodological designs feasible, valid and reliable measurement, and report sufficient detail of their outcomes to permit comparisons across studies. Finally, because wraparound is a team process, but not a specific service, what services were received by a youth and family should become a common practice for wraparound evaluation. While there is intuitive appeal that EBTs could achieve more positive outcomes when delivered through a high-quality wraparound team process, the empirical data must be collected.

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Session 49 » 3:15 - 4:15 pm » Salon J

topical discussion

Promoting Effective Behavioral Health Practices in a Statewide System of Care

Panel: Robert Franks, Jeffrey Vanderploeg, Jennifer Schroeder, Jason Lang, Samanta Matlin, & Jeana Bracey

Introduction

Overview. This session will address efforts in Connecticut to support the development and implementation of effective community-based programs within a statewide system of care. Investigators from the Connecticut Center for Effective Practice (CCEP) will present three projects, each at different stages of development and utilizing various strategies and methodologies.

By the end of this topical discussion we will accomplish four objectives:

- Provide an overview of three initiatives designed to further develop Connecticut's comprehensive system of care.
- Understand how an intermediary agency can serve to promote effective practices through research and consultation.
- Explore challenges, barriers, and successful approaches to system of care development and refinement.
- Exchange information between providers and audience members on lessons learned regarding similar efforts in their own communities.

Purpose. The insights and challenges shared between presenters and audience members will be useful for those wishing to conduct similar work in their own states and communities. For example, novel strategies and methodologies will be introduced relative to each project, with the idea that audience members in other states and communities can utilize similar approaches to develop their own systems of care.

Structure. Presenters will provide a 15-minute overview of each of the three projects that will include interactive discussion with audience members. The final 15-minute segment will involve an interactive discussion summarizing major themes of the work, and broader implications for developing a comprehensive and effective system of care.

Audience. The audience will be invited to engage in discussion throughout each segment of the 60-minute presentation. Discussion will center on overall themes and significance of the projects, insights on the ongoing development of systems of care, and challenges and successes of such work.

Issues to be Discussed

A. Outpatient Services Needs Assessment

In 2008, stakeholders in Connecticut's behavioral health system of care designed a study to better understand the characteristics and needs of the clients served in routine outpatient settings. Investigators at the Connecticut Center for Effective Practice used four data sources for this study: (1) online surveys of outpatient clinicians and clinic directors; (2) on-site interviews with select outpatient providers; (3) focus groups with key stakeholders; and (4) secondary analysis of outpatient claims data.

The study focused on the characteristics of agencies, staff members, and the population served, as well as the complexity needs of children and families' needs. Screening and assessment, service delivery, evidence-based practices, staffing, and data collection also were examined.

Children and families in routine outpatient treatment settings present with highly complex needs and often require extensive case management, however, reimbursement and productivity standards are barriers to case management. The training and experience level of outpatient staff is

variable and has been identified as a barrier to effective treatment. The use of evidence-based practices at this level of care remains limited, as does the consistent use of data to guide service delivery and monitor outcomes. Although recent state initiatives have drastically improved access to care, families still experience significant barriers, especially for children with autism, substance abuse problems, and children in foster care.

B. Wraparound Demonstration

The Connecticut Center for Effective Practice (CCEP) was awarded a Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Transformation—State Incentive Grant (MHT-SIG) to serve as the Coordinating Center to implement the principles and practices of Wraparound in two pilot communities in Connecticut. The aim of this initiative is to build the capacity of participating communities to implement comprehensive services for high-risk youth long after the project has ended.

This project is designed to impact children and youth (ages 6-14) who are at high risk or in the early phases of juvenile justice involvement, and their families. The initiative also targets Connecticut's workforce across multiple systems engaged in service planning and coordination.

This initiative includes the provision of (1) training and technical assistance; (2) coaching; (3) capacity building and administrative support; and (4) data collection and quality assurance procedures that build on each community's strengths.

This presentation will focus on the implementation of the principles and practices of Wraparound in two communities and provide initial findings related to this work. Findings from this initiative will provide a useful framework for other communities and states aiming to improve the implementation of Wraparound to improve systems of care.

C. Trauma-Focused CBT Learning Collaborative

Initial findings from a statewide effort to disseminate Trauma Focused Cognitive-Behavioral Therapy (TF-CBT) to outpatient clinics across Connecticut using the Learning Collaborative methodology will be presented.

TF-CBT has been designated a Model Program by SAMHSA, and clinical trials have shown significant symptom reductions among youth exposed to trauma. However, past efforts to disseminate evidence-based practices (EBPs) in community settings have proven challenging because of the inherent complexity of transforming organizational policies, procedures, and systems.

The Learning Collaborative is a quality improvement model adapted by the National Child Traumatic Stress Network that is designed to facilitate the dissemination and adoption of best practices through system-wide organizational change. Connecticut is one of the first states to utilize this method on a statewide level.

Agency staff members from six clinics per year over three years are participating. Symptom measures from clients and therapist fidelity measures are obtained for assessing progress and program evaluation. Initial aggregate outcomes of state, agency, supervisor, and clinician data, including fidelity data, will be presented. We will discuss implications and challenges of disseminating EBPs on a statewide level using case examples.

Who Should Attend

This Topical Discussion will be most relevant to professionals, students, state government officials and policy makers who are interested in research, evaluation, and consultation that builds individual programs and service systems. To that end, audience members will learn more about innovative strategies and methodologies such as online surveys (used for the outpatient needs assessment), capacity-building strategies (used for the Wraparound initiative), and the learning collaborative methodology (used in the TF-CBT initiative). Researchers and state policy makers can replicate each of these approaches as they seek to improve the effectiveness of their own system of care.

Tuesday, March 3 » 4:15 pm

Session 50 Salon A-B	Discussion Hour—From Good to Great and Beyond: Recent Research on Effective Organizations <i>Robert M. Friedman</i>	Page 195
Session 51 Salon C	Symposium—The Building Bridges Initiative: A Framework for Self-Assessment to Improve Organizational Practices <i>Chair: Robert E. Lieberman</i> Overview of the Building Bridges Initiative and the Framework for Self-Assessment <i>Robert E. Lieberman</i> Design and Structure of the Matrix and the SAT <i>Robert E. Lieberman</i> Field Testing the SAT and Next Steps <i>Richard H. Dougherty</i>	Page 195
Session 52 Salon D	Topical Discussion—Asset-Based Research and a Public Health Approach to Addressing the Needs of Lesbian, Gay, Bisexual, Transgender, Questioning, Intersexed, and Two-Spirit (LGBTQI2-S) Youth and Families <i>Katherine Lazear, Peter Gamache & Sylvia Fisher</i>	Page 197
Session 53 Salon G	Developing Culturally Competent Systems of Care <i>Carolyn Lichtenstein</i> Using Social Network Analysis to Study Inter-Agency Collaboration in Children's Mental Health Service Systems <i>Bhuvana Sukumar</i>	Page 199 Page 200
Session 54 Salon H	Topical Discussion—Strong Communities: Community-Wide Strategies to Keep Kids Safe <i>Patricia Motes, Robin Kimbrough-Melton & Gary Melton</i>	Page 201
Session 55 Salon I	Topical Discussion—Using Finance to Improve Access and Quality of Treatment for Adolescents with Substance Use and Co-Occurring Mental Health Disorders <i>Doreen Cavanaugh, Rick Nance, Bill Janes & Travis Fretwell</i>	Page 202
Session 56 Salon J	Topical Discussion—The Use of Data to Assist the Implementation of Evidence Based and Promising Practices: Systemic, Organizational, and Individual Perspectives <i>James Wotring, David Bernstein, Patrick Kanary & Kari Collins</i>	Page 203

Session 50 » 4:15 - 5:15 pm » Salon A-B

Discussion Hour—From Good to Great and Beyond: Recent Research on Effective Organizations

Presenting: Robert M. Friedman

When the book *From Good to Great* was published in 2001¹, presenting results of research on “great” companies, it rapidly drew extensive interest in the non-profit and governmental world even though its focus was on large for-profit businesses. In the past two years two other books have been published that present research on effective organizations that have important implications for developing strong organizations in the children’s mental health field, and strong systems of care. The purpose of this topical discussion is to briefly highlight some of the key findings from these two books, and to stimulate discussion about the implications for the children’s mental health field.

In 2008, Crutchfield and Grant published *Forces for Good: The Six Practices of High-Impact Nonprofits*.² This book presents findings from a study of large non-profit organizations that have had significant impacts on changing policy and practice in their field. The organizations cover a broad range of fields including food banks, environmental issues, housing, public policy, and particular population groups.

The second book by Sisodia, Wolfe, and Sheth was published in 2007. Entitled *Firms of Endearment: How World-Class Companies Profit from Passion and Purpose*,³ it examines companies that have focused on

developing positive relationships with multiple stakeholders, including employees, customers, partners, and shareholders. The practices and outcomes of these companies are compared with companies in the same field that put their primary emphasis on producing profit and pleasing their shareholders rather than other stakeholder groups.

The methods used in these two studies and the findings from these two books will be presented, and related to the findings of *From Good to Great*, and other approaches to organizational and system development. The audience will be invited to explore the relevance and implications of the findings for their own work within the system of care world.

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Session 51 » 4:15 - 5:15 pm » Salon C

symposium

The Building Bridges Initiative: A Framework for Self-Assessment to Improve Organizational Practices

Chair: Robert E. Lieberman

The purpose of this symposium is to inform participants about the Framework for Self-Assessment that has been developed for the Building Bridges Initiative, a federal effort to foster fully integrated community services systems that include residential treatment. The Framework consists of a Matrix of Performance Guidelines and Indicators and a Self-Assessment Tool (SAT) designed to help a residential treatment organization and its constituent community partners, including family members and youth, assess the degree to which their operations are consistent with the values and guidelines of the Initiative. These instruments are to be field tested to determine their usefulness as assessment tools; we expect this to be completed by the time of the symposium.

The symposium is organized into three presentations. The first presentation will address the Building Bridges Initiative—its purpose and a brief overview of its activities to date. Particular focus will be on the conceptualization upon which the Framework for Self Assessment was established. The second presentation will involve a description of the Matrix of Performance Guidelines and Indicators and the specifics of the Self-Assessment Tool (SAT). The final presentation will focus on the design of the field testing project and describe preliminary results and next steps being planned for the Initiative. A closing discussion with session attendees will solicit feedback about conceptual and technical level issues and the use of the tool to improve quality.

Overview of the Building Bridges Initiative and the Framework for Self-Assessment

Presenting: Robert E. Lieberman

Contributing: Richard Dougherty, Sylvia Fisher & Anne Kuppinger

Background

The Building Bridges Initiative is a national effort to advance a set of values and principles for comprehensive, coordinated, and collaborative community approaches to address the needs of children with significant emotional and behavioral disorders and their families when the child’s condition necessitates residential treatment. These values and principles are articulated in a Joint Resolution that was developed by a nationwide “summit” of family members, youth, and professionals in June 2006. The Joint Resolution to Advance a Statement of Shared Core Principles: Building Bridges Between Residential and Community Based Service Delivery Providers, Families and Youth articulated the following basic principle:

Residential and community-based services and supports must be thoroughly integrated and coordinated; and, residential treatment and support interventions must work to maintain, restore, repair, or establish youths’ relationships with family and community.

The Joint Resolution also: (a) delineated the importance of creating a comprehensive service array for children, youth, and families; (b) established defined areas of consensus, related to values, philosophies, and services; (c) identified emerging best practices in linking residential

and community services; (d) set the stage for strengthening relationships and promoting consensus building; and (e) identified action steps for the future. Since June, 2006, several workgroups have elaborated on aspects of the Joint Resolution (including at a follow up summit in September 2007) to articulate strategies that support effective linkage and collaboration between providers of residential and community-based services and supports.

One of the follow up efforts from the 2006 Summit was to create a set of outcome indicators that describe what a family or youth might expect if services and supports were provided in a manner that is consistent with the Building Bridges Joint Resolution. This task was assigned to the Outcomes Workgroup of the Building Bridges Initiative, a group of volunteers from the participants at the two summits. The workgroup developed a matrix of Performance Guidelines and Indicators. With the guidance of the Building Bridges Steering Committee, the workgroup also took on a corollary task of designing a Self-Assessment Tool (SAT) with which an organization and community could evaluate itself against the performance guidelines and indicators of the matrix. The work of the Outcomes Workgroup has been an iterative process, with development and ongoing reviews of the product by the members of the workgroup, and ongoing input from the Building Bridges Summit participants, Steering Committee, and Youth and Families Workgroup, as well as national provider associations, the Outcomes Roundtable for Children and Families, and other interested parties.

Conceptualization

The Building Bridges Initiative is an effort to stimulate the development of practices that explicitly integrate all levels of care within local community systems. It is a response to the schism that has emerged in many locations around the country between community services and/or systems of care and residential treatment. Through the Comprehensive Community Mental Health Services for Children and their Families Program, over 125 communities nationally have received federal grant funds to develop coordinated community systems. This federally-supported effort has resulted in the generation of an incredible wealth of research-based knowledge regarding best practices in delivering coordinated services, much of which has been widely disseminated. However, other than in limited locations nationally, residential treatment has not been explicitly integrated into the design or the learning associated with systems of care. Since a significant cohort of children and youth with serious emotional and behavioral disorders access residential treatment at some point, this disconnect has at times impeded efforts to deliver the most effective supports and services possible.

For this reason, Building Bridges activities have focused on the integration of residential treatment into comprehensive community efforts. Nonetheless the “urgent need for transformation” articulated in the Joint Resolution cuts across all community systems, services, and supports. The initiative is a broad construct that envisions shared responsibility, values, and best practices with an emphasis on the family and community in addition to the child. The integration of residential treatment into community systems involves transformation of mindset and practice for all who work with children and families in community settings (e.g., child welfare, juvenile justice, education, mental health, etc.), as well as residential providers, payers, policymakers, family members, and youth.

Creating performance guidelines and indicators for an initiative of this size and nature is challenging. A performance guideline or performance indicator begs the question: who is responsible for its implementation and achievement? When considering integrated systems with a high degree of mutual interdependence, this question is not easily answered, because the answer may very well be that several entities share the responsibility. Building Bridges is asking community systems,

including residential providers, child welfare workers, probation officers, mental health workers, and educators, to adopt new protocols for themselves and their work with each other. Most importantly, it is asking all of the professionals across systems to understand, embrace, and adopt family driven, youth guided, and culturally and linguistically competent best practices in all of their work.

The matrix and SAT have been developed to be used for the purpose of quality improvement. It is envisioned that communities and organizations seeking to implement the values and practices of the Building Bridges Resolution would use these instruments collaboratively and supportively. They have been designed to point to specific best practices, not prescribe them. A glossary and resource guide have been developed to serve as companion documents to the SAT. These are intended to help individuals and organizations understand the terminology used in the instruments and to research the specific interventions and practices that will successfully implement the performance guidelines and indicators.

Design and Structure of the Matrix and the SAT

Presenting: Robert E. Lieberman

Contributing: Richard Dougherty, Anne Kuppinger & Sylvia Fisher

This presentation will present the Matrix of Performance Guidelines and Indicators and the Self-Assessment Tool (SAT) that have been developed by the Outcomes Workgroup of the BB Initiative, with the guidance of the Building Bridges Steering Committee.

The goal of both of these instruments, the matrix and the SAT, is to provide guideposts for operationalizing processes and practices that implement the Joint Resolution, in the form of tools with which efforts can be evaluated for quality improvement purposes. The objective is that, taken together, these performance guidelines and indicators will provide evaluative and measurement information about the: (1) degree of continuity, seamlessness, and integration of services and supports in local communities, and; (2) extent to which known best practices are being utilized in residential and community settings alike.

The matrix focuses on the linkages, or bridges, between residential treatment programs and community systems, as well as the practices that occur in both types of settings. It has been designed with three columns to identify guidelines and indicators that ideally would be in place for youth prior to a potential residential episode, during an actual residential episode, and after residential treatment. Cross-cutting practices that should take place in all three of these phases are identified across the top of the columns.

Broad outcome measures that might be expected from the provision of linked and integrated treatment are identified across the bottom of the columns. The types of community resources that are referred to in several of the items in the matrix are also specified across the bottom of the columns. This reflects the comprehensive community collaboration and supports needed to implement the values, principles, and practices of the Joint Resolution.

The matrix columns are divided into performance guidelines and indicators, defined as follows:

- **Performance Guidelines** are expectations of the practices and processes that occur in the provision of care, services, and supports. These can be assessed through observation, survey, interview, or chart review.
- **Performance Indicators** represent measures that can be tracked, producing ‘hard data’ with a numerator and denominator, typically using existing administrative data sets.

The SAT offers a tangible operationalization of the content within the matrix. Designed to be completed by staff of residential programs and

purchasers, community agencies, family members, youth and others, the SAT will yield data regarding the degree to which both the residential program and community partners are perceived to meet the principles and values of the Joint Resolution.

To truly begin a collaborative process of improvement, the SAT was designed to be completed by groups of staff, family members, youth and others in the community. While responses are not to be personally identified, the responses are designed to be analyzed by respondent groups with a particular focus on those areas where groups perceive significant differences. This might be found in different average scores across subgroups or in responses that reflect markedly different opinions. The results can then be reviewed by a cross-functional improvement team that includes residential, family, youth and community representatives and whose goal is to identify areas for improvement. These might include steps ranging from better communication with family members regarding existing policies, to adopting new treatment approaches, to redesigning professional development activities.

Results of a field test of the SAT with eight residential treatment centers from around the country will be shared. The field test was designed to determine the usefulness of the matrix and the SAT and the degree to which they accurately assess a provider and community's practice against the principles and practices articulated in the Joint Resolution. Qualitative and quantitative results as well as implications of the results for instrument revision will be discussed.

Field Testing the SAT and Next Steps

Presenting: Richard H. Dougherty

Contributing: Sylvia Fisher, Robert Lieberman & Anne Kuppinger

This presentation will share and discuss preliminary results of field testing undertaken to determine the usefulness of the matrix and the SAT and the degree to which they accurately assess a provider and

community's practice against the principles and practices articulated in the Joint Resolution.

The field testing project was designed to provide an initial evaluation of the degree to which the Matrix and the SAT were achieving the objectives for which they were designed. DMA Health Strategies (DMA) from Lexington, Massachusetts has been selected to conduct the field testing. A group of eight residential treatment centers from around the country are to be recruited for the field testing, based on criteria established by the Steering Committee. Qualitative and quantitative results will be aggregated and analyzed by DMA. Field testing is expected to be short in duration and preliminary results will be available to share during the symposium.

Next steps for the Outcomes Workgroup will involve following up on the Field Test results through the revision of the Matrix and the SAT. It is anticipated that the field testing will yield information about the degree of clarity in the matrix and the SAT, resulting in potential revisions to both instruments. Field testing results should also demonstrate how information generated by use of the instruments can be utilized for quality improvement purposes. Finally, it is hoped that data regarding the shared responsibility of residential providers and community partners will result in the development of new and different practices in the test sites, thereby yielding information regarding the effective implementation of the Building Bridges Initiative.

Next steps for the Outcomes Workgroup and the overall Initiative will be presented and attendees will be asked to discuss the matrix and SAT and the field testing, and to provide comments and input. Emphasis in the discussion will be placed on steps necessary to make this self-assessment a truly useful tool for quality improvement and transformation of community and residential systems. The Building Bridges Initiative overall will be guided by these results in its efforts to design and support training and technical assistance for communities across the nation.

Session 52 » 4:15 - 5:15 pm » Salon D

Topical Discussion

Asset-Based Research and a Public Health Approach to Addressing the Needs of Lesbian, Gay, Bisexual, Transgender, Questioning, Intersexed, and Two-Spirit (LGBTQI2-S) Youth and Families

Panel: Katherine Lazear, Peter Gamache & Sylvia Fisher

Introduction

Much of the LGBTQI2-S focused research today has been deficit and problem based. The purpose of this discussion will be to focus on asset-based research (i.e., resiliency, social support models, cultural competence capacity models, participatory research), utilizing a public health approach within a system of care to meet the needs of youth and other family members who are LGBTQI2-S and their families, and review of a trauma-informed curriculum and promising programs meeting the needs of youth who are LGBTQI2-S. The audience will be asked to respond to asset-based models and the trauma-informed curriculum, and discuss research, promising approaches and programs in the field.

Issues to Be Discussed

Using comparative estimates of the percentage of individuals who are LGBTQI2-S in the total population of between 2-10%, an estimated number of children who are LGBTQI2-S between the ages of five and eighteen would be 1,065,858 to 5,329,292. While teenagers are coming out as LGBTQI2-S at younger ages (Setoodeh, 2008; Elias, 2007; Kreiss & Patterson, 1997), racial/ethnic youth in Black and Latino communities

have been found to disclose their homosexuality to fewer others than their White peers (Rosario, Schrimshaw, & Hunter, 2004), indicating greater degrees of underestimation cited in the research literature. This population often experiences social signals of exclusion in the form of negative beliefs and attitudes, stigma, stereotypes, and targeted violence such as bullying, harassment, and abuse, intrapersonal uncertainty when acknowledging, disclosing or asserting their sexual orientation and/or gender identity within new or unfamiliar settings. Multidimensional challenges related to the coming out process necessitate adaptation and resilience (Doueck & Maccio, 2002; D'Augelli, 2002; Oswald, 2002; Rosario, Hunter, Maguen, Gwadz, & Smith, 2001; Fisher, Easterly, & Lazear, 2008).

The first meeting of the Research Collaborative on Issues Affecting LGBTQI2-S Youth and Families was held at the Research and Training Centers' 21st Annual Conference for Children's Mental Health in Tampa, Florida (2008). A major concern of the Collaborative was the importance of not labeling LGBTQI2-S youth as having mental health problems, but recognizing that mental health problems can stem from events and societal responses that happen to someone who is, or is perceived to be LGBTQI2-S. A clear message emerged—to maintain a holistic approach with a focus on the enhancement of positive self-esteem (Lazear & Gamache, 2008).

Caution has been expressed that an overarching focus on problems (i.e., suicide, HIV/AIDS, homelessness) associated with LGBTQI2-S individuals in the research literature and mental health field may pathologize sexual orientation and gender identity as causing negative outcomes (NAMI, 2007; Bakker & Cavender, 2003; Meyer, 2003; Harper & Schneider, 2003). In addition, harm reduction approaches that largely center on risks associated with being LGBTQI2-S (i.e., the person-at-risk model) can ignore how individuals who are not LGBTQI2-S can mistakenly be perceived as such and experience both hate crimes and hate incidents (USDOJ, 2004; Herek, 2003).

This topical discussion proposes a framework for LGBTQI2-S research that focuses on assets and the public health context associated with meeting the needs of LGBTQI2-S persons. This framework is presented for a number of reasons: (1) the assets-based research on this population is minimal, necessitating an adaptation of assets-based research from other populations; and (2) the focus of LGBT research for so long has been on the problem/harm approach that it creates a sense of inevitability that existing as LGBTQI2-S will lead to being in harms way. The assets-based approaches presented—resiliency, social support models, community focused and organization focused cultural competency models, and family and youth participatory models can be structured within a population-based approach, that is, a public health approach concerned with the health of all people, including their relationship to the physical, psychological, cultural, and social environments in which people live, work and go to school. A growing body of literature is moving in this direction.

Risk and resilience factors associated with a LGBTQI2-S identity are salient to mental health providers seeking to uphold system of care principles, improve quality of care, and increase effective outreach, engagement, treatment, and support for this population. Effective services and supports to youth and families who are LGBTQI2-S requires that both processes and structures in systems of care be addressed, including frontline practice shifts that focus on the skills, knowledge, and attitudes of service providers, evidence-based practices and promising approaches, treatment efficacy monitoring, and ongoing evaluations for continuous quality improvement (Pires, 2002). For example, the National Association of State Mental Health Program Directors (NASMHPD, 2006) and National Child Traumatic Stress Network (NCTSN, 2006) created a trauma-informed curriculum geared to the needs of traumatized youth in residential and juvenile justice facilities. Recognizing that youth who are LGBTQI2-S are frequently traumatized (i.e., personal experience of interpersonal violence, sexual abuse, physical abuse, severe neglect, loss, and/or the witnessing of violence) as a result of their sexual orientation, gender identity, or questioning status, this curriculum has been adapted by the Center for Mental Health Services, Child, Adolescent, and Family Services Branch to address the needs of these youth. Curriculum modules examine definitions and consequences of trauma, the bio-psychosocial impact of trauma, basic concepts in trauma informed care, trauma sensitive tools, and means of executing leadership in organizations interested in addressing the needs of traumatized LGBTQI2-S youth.

Future research methodologies must examine assets-based approaches, such as the impact of positive development programs; stigma reduction strategies; positive role models and adult connections; supportive family settings; and, how peer-to-peer support organizations reduce stigma, social withdrawal and isolation. Future research can build on the work mentioned above, as well as other inclusive initiatives across the country. Research can identify the critical variables in promising practices that can be adapted to programs and communities. Research can also take a strengths-based approach and focus on how to infuse inclusionary and asset-based approaches that are responsive to this population into existing systems of care and professional training.

Who Should Attend

All individuals involved in the development, evaluation and implementation of services and supports, for youth and their families, (i.e., providers, program staff and directors, families, youth, researchers and evaluators, including those with a special interest in LGBTQI2-S issues).

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Session 53 » 4:15 - 4:45 pm » Salon G

Developing Culturally Competent Systems of Care

Presenting: Carolyn Lichtenstein

Contributing: Sylvia K. Fisher, Phyllis Gyamfi, Freda Brashears & Stephen Forssell

Introduction

Cultural competence is one of the core principles of systems of care. The principle of cultural competence asserts that services delivered to children and their families should be provided in a culturally sensitive manner, and that cultural values and traditions should be considered and incorporated into the planning and provision of services. The national evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program has gathered data on how grant communities funded in 2005 and 2006 are incorporating cultural and linguistic competence principles into the early stages of their system of care implementation.

This paper examines how the initial cultural and linguistic competence efforts of a cohort of system of care grant communities are related to other characteristics of these communities, including service populations. The paper also examines how the CLC efforts are related to services provided and family experiences with these services.

Methodology

The national evaluation includes a study examining the extent to which grant communities implement system of care core principles, called the *System of Care Assessment*. This study involves site visits by national evaluation staff to grant communities during the 2nd, 4th, and 6th years of their grants. These site visits produce detailed reports describing how communities are incorporating each of the core principles into their system of care design and implementation, as well as scores indicating the extent to which the core principles have been incorporated into various domains of both system infrastructure and service delivery. This analysis will examine the System of Care Assessment data pertaining to the cultural competence principle specifically.

The national evaluation also includes a Cultural and Linguistic Competence (CLC) Study. A substudy stemming from the CLC study is the *Cultural and Linguistic Competence Implementation Substudy (CLCIS)*, which details the ways in which the cultural and linguistic contexts of four communities inform the implementation of their systems of care.

The data from these two studies will be combined with national evaluation *Longitudinal Child and Family Outcome Study* caregiver interview responses describing their families' service experiences. Data on services received and how well those services met the youth's and family's needs will be analyzed, as well as data on caregiver perceptions of their families' experiences with services provided, including access, participation in treatment, cultural sensitivity, satisfaction, and outcomes.

Findings

Results of the CLCIS show that the four communities that participated expended efforts toward reducing cultural and linguistic disparities within children's mental health systems of care prior to implementing their CMHI grants. Such efforts vary by community. Current strategies include training, policies, assessment, family and youth empowerment strategies, translation, evaluation, and adaptations of treatment practices. However, results of these strategies are often mixed, and some communities have been more active in implementing them than others. Thus, the challenge of trying to address cultural and linguistic competence in dynamic and unique communities remains.

Additional analysis will provide insight into the implementation of culturally competent systems of care. This analysis will also provide a better understanding of the degree to which a system of care reflects cultural competence and how this level of development is related to other community characteristics and to the service experiences of community members.

A preliminary examination of the System of Care Assessment cultural competence average infrastructure and service delivery scores indicates that there is substantial variation across communities. One of the primary analyses to be conducted will be to better understand the community factors related to this variation, through examinations of the site visit reports associated with the scores and other characteristics of the communities.

Examining the relationship between cultural competence scores and family service experiences will rely on quantitative analyses supported by qualitative analysis for deeper understanding. Statistical analyses such as regression will be used to examine trends and patterns at the community level. An example of this type of analysis is modeling the relationship between the System of Care Assessment cultural competence service delivery scores, the percentage of caregivers from different ethnic groups at each community reporting the receipt of particular services. Multi-level modeling of individual caregiver responses related to community-level characteristics and System of Care Assessment scores will also be conducted.

Conclusions

The system of care core principle that the services be delivered in a culturally competent manner, which requires that a culturally competent system of care infrastructure be developed, is one of the most difficult principles to implement and yet one of the most crucial for effective service provision. This analysis will provide greater insight into the complexities of implementing this core principle in recently funded CMHI grant communities.

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Using Social Network Analysis to Study Inter-Agency Collaboration in Children's Mental Health Service Systems

Presenting: Bhuvana Sukumar

Contributing: John Gilford, Yisong Geng & Brandee Brewer

Introduction

The system of care concept emphasizes the importance of developing partners at multiple levels in order to deliver effective services to children and families. Because children in systems of care often have multiple agency involvement, interagency collaboration is vital, as children and families rely on the input and support from these agencies, as well as service providers, and community organizations to provide well-needed resources. Social Network Analysis (SNA) is an innovative methodology that can be used to understand these ongoing transactions or interactions and the implications of interaction patterns between agencies or groups. SNA maps and measures the relationships between people, groups, organizations, and other knowledge-processing entities. Each network consist of nodes (people or groups) that are connected to each other, creating links that delineate the relationship between individuals and/or groups (Hanneman & Riddle, 2005). SNA provides both a visual and a mathematical analysis of relationships and can be used to examine interagency collaboration. The results from such analysis can potentially lead to improved policy outcomes through better understanding of network/systems structure and the factors that inhibit or facilitate collaboration.

Like systems of care, the SAMHSA funded National Child Traumatic Stress Network (NCTSN) was initiated as a model of interagency/entity coordination and collaboration that is involved in the development, testing, organization, and delivery of quality care to children and their families who have experienced trauma. The three-tiered organizational structure of the NCTSN (Category I, II, and III centers) is designed to foster collaboration between centers and is expected to expand the knowledge base for evidence-based treatment of child traumatic stress. The Category I center includes two lead grantees that collaborate with SAMHSA to serve as the Network's national coordinating center, providing technical assistance to Network centers. Category II centers are typically academic institutions providing expertise regarding the development and evaluation of trauma-specific treatments and interventions for diverse clinical and demographic populations. Category III centers primarily provide direct mental health services to children and their families and implement and evaluate interventions in community based settings.

In this study, using data from the cross-site evaluation of the National Child Traumatic Stress Initiative, we detail SNA measures that can be used to quantify patterns of decision making and discuss how these measures could be used to facilitate the design and measure the outcomes of interventions to change organizational behavior in the system of care program. This presentation will discuss methods and findings and will review the application of SNA in systems of care context. In addition, resources for local implementation of an interagency collaboration tool and social network analysis will be discussed.

Method

A web-enabled Network Survey assessed collaboration by inquiring about the extent to which each NCTSN center has interacted with every other center in the previous 12 months on select key NCTSN activities (governance/decision making, information sharing, coordination of activities, product development, product dissemination and adoption,

and training and technical assistance). Administered in alternate years over a five year period, the Network Survey also contains items concerning factors that facilitate or inhibit collaboration. Targeted survey respondents include the center director and a center associate director or project coordinator. The Network Survey was initially administered in July 2006 to 85 respondents from 44 currently funded NCTSN centers. Approximately 73% (62 respondents) of the sample completed the survey. Of the 15 alumni centers, 33% (five respondents) completed the survey. Approximately 80 centers were recruited to participate in the second administration of the Network Survey in June 2008; 90 respondents from 62 centers completed the survey (65% response rate). Data from the 2006 and 2008 administrations of the Network Survey were analyzed using social network analysis (SNA) to identify levels of interorganizational communication, clusters of activity, which centers were integral to collaboration and change in interaction over time.

Discussion

The findings from the Network Survey indicate that the NCTSN is centralized and well integrated. In addition, the findings highlight several key characteristics of the NCTSI Network. Findings indicate that the Category I center was seen as a central player and the glue that held the Network together, especially on governance, product development, and dissemination and product adoption. As expected, there was a great deal of communication between NCTSN centers and the Category I center. Examination of change in the number of collaborative relationships indicated that, overall, for all network measures, the number of collaborative relationships decreased significantly, with exception to the product development domain. A Z test of the mean density in 2006 and 2008 was conducted, and a significant decrease in density was found from 2006 to 2008 in governance ($Z = -6.45, p < .01$), dissemination and adoption of products ($Z = -5.87, p < .01$), training provided ($Z = -6.26, p < .01$), training received ($Z = -4.65, p < .01$), hosting conferences ($Z = -6.16, p < .01$), and coordinating activities ($Z = -4.78, p < .01$). There were no significant differences in collaboration on the product development activity between 2006 and 2008, which indicates that the interaction on this domain remained the same and did not decrease between survey administrations. Center collaboration appeared to focus more on product development and less on product adoption and trainings, which to a certain extent may be related to the pattern of peripheral involvement of some Category III centers when they should be collaborating more, at least on Network activities, such as product adoption and trainings.

In this presentation, we introduce the application of social network analysis to analyze interagency collaboration in the field of children's mental health and to assess the relevance and impact of this analysis in the system of care program. Policymakers, administrators and program directors could use SNA data to examine relationships and to map strategies for overcoming barriers to collaboration.

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Topical Discussion

Strong Communities: Community-Wide Strategies to Keep Kids Safe

Panel: Patricia Motes, Robin Kimbrough-Melton & Gary Melton

Introduction

In 1990, the US Advisory Board declared a national emergency in the child protection system. The Board argued that a universal system of family support, grounded in the creation of caring communities, was needed to ensure children's safety (ABCAN, 1990; 1993). Strong Communities is the first initiative to conduct and evaluate a comprehensive, large-scale implementation of the Board's proposed strategy.

Begun in 2002 with substantial funding from the Duke Endowment, Strong Communities builds systems of support for families of young child through community-wide prevention and intervention (Melton, in press; Kimbrough-Melton & Campbell, 2008). The vision of Strong Communities is for every child and every parent to be confident that someone will notice and someone will care whenever they have reason to celebrate, worry or grieve. Strong Communities works to accomplish these goals through partnerships with schools, civic groups, businesses, housing agencies, health agencies, law enforcement, religious organizations, social service agencies, and individuals. Volunteer partners are central to the broad-based community engagement of this initiative.

Issues to Be Discussed

Presenters in this session will facilitate an interactive discussion by highlighting the two primary strategies of this initiative: (1) outreach for the purpose of building community and changing norms, and (2) coalescence of existing community physical and human resources in direct support to families with young children. Presenters will also share research findings that demonstrate the promise of Strong Communities. Participants will be encouraged to offer input and direction to sustain and replicate this initiative.

Within Strong Communities, outreach activities are:

- logically related to the prevention of child abuse and neglect, not simply to the promotion of child or community well-being,
- directed toward the transformation of community norms and structures,
- continually "pushing the envelope,"
- undertaken to recruit, mobilize, and retain volunteers,
- directed toward the establishment or enhancement of relationships among families or between families and community institutions,
- focused on the development of widely available, easily accessible, and nonstigmatizing social, emotional, and material support for families of young children,
- directed toward parents, and implemented in a manner to enhance parent leadership and community engagement, and designed to promote reciprocity of help, and
- designed so supports build or rely on the assets (leadership, networks, facilities, and culture) in and among primary community institutions.

The direct support to families component of Strong Communities is termed Strong Families. Strong Families is a network of activities and services designed to assist parents with children six years old and younger in nurturing their children, using resources within their community, and joining supportive networks that encourage families to watch out for each other.

Key components of Strong families include:

- Family Activity Centers that offer
 - » Family activities and play groups
 - » Parent-child activities
 - » Parents' Night Out
 - » Financial and career education, counseling, and mentoring
 - » Chat with a Family Advocate – "plain-label" professional assistance
- Family Support
 - » Extra Care—support through health sector for families with very young children
 - » Family Partnerships—support to families of children in public kindergarten programs; preventive roles for mental health professionals
- Intensive Family Support
 - » Building Dreams—volunteer mentoring and other supports to children and families affected by parental incarceration
 - » Safe Families—volunteer provision temporary in-home care and other supports for families needing and seeking such supplementary care.

Highlights of Research Findings

In the first six years of the initiative, approximately 5,000 volunteers (community organizations and individuals) contributed at least 55,000 hours, typically in multiple kinds of activities. In community surveys conducted in 2004 and 2007, parents in the service area reported greater social support, more frequent positive parental behavior, more frequent use of household safety devices, less frequent disengaged (inattentive) parenting and less frequent neglect. These findings are across time and relative to matched communities. Surveys within schools indicate significantly increased beliefs of parents, teachers, and especially children that (a) kids are safe at or in transit to school and (b) that parents are taken seriously. Such beliefs have become less common in families of children in matched comparison schools.

Who Should Attend

Key audiences are policy makers, community mobilizers, mental health professionals, health professionals, educators, family advocates, community members, program planners, researchers, and evaluators.

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Session 55 » 4:15 - 5:15 pm » Salon I

Topical Discussion

Using Finance to Improve Access and Quality of Treatment for Adolescents with Substance Use and Co-Occurring Mental Health Disorders

Facilitator: Doreen Cavanaugh

Panel: Rick Nance, Bill Janes & Travis Fretwell

Introduction

This topical discussion will introduce the concept of financial mapping to an audience interested in service system development. Speakers will provide a brief overview of the financial mapping process, share results from the financial mapping process in three states (Illinois, Florida and Georgia) and discuss strategies for employing findings to develop a financing infrastructure to support a continuum of treatment and recovery services for adolescents with substance use and co-occurring mental health disorders.

Participants will understand the purpose and elements of the financial mapping process and will learn about the opportunities and challenges of differing state approaches of using finance to improve access to and the quality of treatment for adolescents with substance use/co-occurring mental health disorders. Participants will understand the potential to use the financial mapping process to achieve a more efficient and effective behavioral healthcare system.

Issues to be Discussed

In 2005, the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA), awarded grants to fifteen States and the District of Columbia to improve the state infrastructure supporting the treatment system for adolescents with substance use and co-occurring mental health disorders. The State Adolescent Substance Abuse Treatment Coordination (SAC) grant is a three-year SAMHSA infrastructure grant program focused on five areas of service system development: interagency collaboration, coordinated financing, workforce development, the dissemination of evidence-based practices and family involvement. This discussion will focus on financial mapping, the process of conducting an inventory of all federal and state financial resources available to support treatment for adolescents with substance use and co-occurring mental health disorders.

Mr. Nance will introduce financial mapping and describe how to accomplish a financial map. He will identify the purpose of financial mapping, and discuss how financial mapping can be used to improve treatment for adolescents with substance abuse/co-occurring disorders. He will discuss Illinois' recently completed financial map of the state's FY 2006 expenditures for adolescent substance abuse treatment. This presentation will highlight challenges Illinois faced and provide results from the state's completed map. Illinois found that in State Fiscal Year 2006 over seventy percent of its state substance abuse treatment expenditures supported twenty-four hour care. The state also discovered that its Department of Juvenile Justice was not maximizing its Medicaid Federal Financial Participation. Mr. Nance will conclude by discussing how the state of Illinois is using this information to guide changes in its adolescent substance abuse treatment infrastructure.

Mr. Janes will discuss Florida's efforts to identify and overcome the many funding barriers that make it difficult for adolescents and their families to access treatment. Among the barriers being addressed through the Florida SAC Grant are: insufficient access to appropriate levels of care; gaps in services; difficulties in obtaining Medicaid authorization and other third party payments; low reimbursement rates for behavioral health services; the absence of billing codes for co-occurring disorders; and conflicts in data collection mechanisms within State agencies and provider organizations that make it challenging to develop common nomenclature and definitions of services.

In Florida, the challenges of making sweeping changes at the State level have been complicated by budget cuts that require the treatment system to respond to increasing demands for services without the benefit of increased funding. Mr. Janes will address meeting the challenge through the development of a more economically efficient system of care characterized by improved resource sharing between agencies and through more effective treatment approaches that engage customers earlier in the process. This more economically effective approach is leading to improved treatment outcomes, reductions in recidivism, and reduced demand for higher, more costly levels of care.

The state of Georgia recently has undergone significant changes to its behavioral health financing system. Mr. Fretwell will discuss these changes to Georgia's behavioral health system. He then will identify the questions that Georgia's financial mapping workgroup asked when it initiated its analysis of adolescent substance abuse and mental health treatment expenditures.

Mr. Fretwell will address key findings such as the realization that in Georgia state general revenue funds, TANF, Medicaid, Title IV-E and the Substance Abuse Prevention and Treatment Performance Partnership Block Grant (SAPTPPBG) and the Community Mental Health Services Performance Partnership Block Grant (CMHSPPBG) were the primary funding sources for Georgia adolescent behavioral health treatment services in FY 2006. The financial mapping process identified over \$590 million dollars in adolescent substance abuse and mental health treatment spending in FY 2006. Mr. Fretwell will describe the lessons learned from the financial mapping and how Georgia plans to implement the findings of this analysis.

Who Should Attend

Representatives from state and county mental health, substance abuse and Medicaid funding authorities should attend this session as well as treatment providers and family members.

Session 56 » 4:15 - 5:15 pm » Salon J

Topical Discussion

The Use of Data to Assist the Implementation of Evidence Based and Promising Practices: Systemic, Organizational, and Individual Perspectives

Facilitator: James Wotring

Discussants: David Bernstein, Bill Carter & Kari Collins

Introduction

The purpose of this session is to identify and discuss the challenges faced by systems, organizations, and individuals implementing evidence based/promising practices (EB/PP) with a specific focus on how they have used data to meet these challenges. In the context of this discussion, 'data' are broadly defined and includes organizational, systemic, financial, and clinical components. The panel will share how they have used data to prepare systems, organizations, individuals, and other stakeholders, for the implementation of EB/PP's. They will provide examples of how data are used to engage and monitor implementing EB/BP's. The examples will be used to stimulate discussion with the audience. The audience will be active participants throughout the process sharing insights or solutions they have found applying data to the many challenges associated with implementing evidence based and promising practices. This session will build on previous presentations from individuals implementing evidence based/promising practices at various levels.

Topical discussions questions will include:

- What data sets related to EBPs implementation are necessary?
- How can data be used to engage stakeholders?
- How can data be best presented to a variety of stakeholders?
- How does data inform organizational and clinical practice?
- What do System of Care leaders need to know?

Issues to be Discussed

As state and local systems implement evidence based practices they face many new challenges associated with workforce development, financing, and building an infrastructure to support the learning of new skills by individuals. The challenges will be described from three levels: system, organization, and individual. The presenters will share examples of how they use data to meet the challenges facing these three levels and share solutions to try to resolve these challenges. The information from this session associated with workforce development will be used to influence a paper that is being written by some of the presenters associated with the consortium to support the implementation of evidence based/promising practices (Child and Family Evidence Based Consortium).

Who Should Attend

The prospective audience for this discussion will be individuals interested in or currently involved with implementing evidence based or promising practices. This may include administrators, managers, educators, or students and those interested in system and organizational change.

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Poster 1

The Effects of the Rater on Racial Differences in Child Behavior Problems

Presenting: Melissa Azur

Contributing: Crystal Barksdale, Elizabeth Stuart, Bhuvana Sukumar & Christine Walrath

Introduction

Previous research on disparities in children's mental health suggests that minority children are less likely to have internalizing and more likely to have externalizing problems than Caucasian children.¹⁻³ Efforts to understand racial/ethnic differences are complicated by the fact that perceptions of child mental health problems, irrespective of race/ethnicity, often vary depending upon the person identifying the problem. While a substantial body of literature has investigated whether raters agree upon the existence of a mental health problem in children, less attention has been given to how a rater's perception of mental health problems may help our understanding of racial/ethnic differences in children's mental health. This study uses data from the national evaluation of the Children's Mental Health Initiative to examine racial/ethnic differences in internalizing and externalizing problems and whether those differences vary for caregivers, clinicians, and the youth themselves.

Method

Sample

The sample ($N = 5806$) for the study uses baseline data from Caucasian, African American, American Indian/Alaskan Native, and Hispanic youth ages 11-18 years participating in the longitudinal outcomes study of the national evaluation. Asian, Pacific Islander, and multiracial children were excluded from the sample due to small sample sizes.

Measures

Information on internalizing and externalizing problems was obtained from the Child Behavior Checklist (CBCL) (caregiver report),⁴ the Youth Self Report (YSR) (youth report),⁵ and DSM diagnoses extracted from clinical records (clinician report). The CBCL and YSR are valid and reliable instruments used to assess symptoms of behavior problems. In the current study, the standardized broad-band internalizing and externalizing scores were used. Scores greater than or equal to 60 were suggestive of clinical problems. Clinician diagnoses were selected to resemble the items that comprise the CBCL and YSR internalizing and externalizing syndrome scores. Clinician rated internalizing problems were defined as any mood or anxiety disorder diagnosis and clinician rated externalizing problems were defined as a diagnosis of conduct disorder, oppositional defiant disorder, or disruptive behavior disorder. Functional impairment was measured with the Child and Adolescent Functional Assessment Scale.⁶ Sociodemographic characteristics were obtained from caregivers.

Analysis

Random effects logistic regression models were used to estimate the effects of race/ethnicity on internalizing and then externalizing problems in youth. Models were built in stages. In the first stage, the unadjusted effects of the variables were estimated. Next, the effects of race on internalizing, followed by externalizing problems, were estimated adjusting for the covariates. Finally, an interaction term between race/ethnicity and rater were entered into the model, again adjusted for the other covariates.

Findings

Internalizing Problems

In adjusted analyses, African American, American Indian/Alaskan Native, and Hispanic youth were less likely to have internalizing problems than Caucasian youth, and youth and clinicians were less likely to identify children with internalizing problems than caregivers. When the interaction

between race and rater was added to the model, the main effects for race and rater continued to be significant, and there were significant interactions for African American and American Indian/Alaskan Native youth.

For example, compared to Caucasian youth, African American and American Indian/Alaskan Native youth were less likely to have internalizing problems when their caregivers identified the problems; however these differences diminished or were eliminated all together when the youth themselves identified the problems.

Externalizing Problems

In adjusted analyses, Hispanic youth were less likely to have externalizing problems than Caucasian youth, and youth and clinicians were less likely to identify externalizing problems than caregivers. When the interaction was added to the model, there were main effects for African American and American Indian/Alaskan Native youth, the association for Hispanic youth was no longer significant, and there were significant interactions between race and rater for African American and American Indian/Alaskan Native youth. For example, African American and American Indian/Alaskan Native youth were less likely to have externalizing problems when their caregivers identified the problems, while they were slightly more likely to have externalizing problems when clinicians assessed the problem.

Conclusions

The findings suggest that racial differences in internalizing and externalizing problems exist for some children and that the magnitude and direction of these differences depends, in part, on who is identifying the problems. These differences seem particularly salient for caregivers and clinicians. Stigma, awareness regarding cultural influences, and an understanding of normative developmental behavior could all contribute to how child behavior is perceived and at what point children are referred for mental health services. Differences in perceptions of problems could create challenges in developing a collaborative partnership between the clinician, youth, and family, and could result in conflicting treatment goals. Further investigation is needed into individual, family, and societal factors that influence how mental health problems are perceived in minority and non-minority children and how those differences affect access and adherence to care, as well as the type of mental health care received.

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Poster 2

Ohio Problem Scale: Implications of CFA Model Misfit for Scale Utility

Presenting: Harold Baize & Rick Jackson

Introduction

The Ohio Scales (Ogles, Melendez, Davis, & Lunnen, 2000) are a set of measures designed for the ongoing assessment of mental health services for children. The scales measure problems, functioning, hopefulness, and satisfaction. The scales promise to answer the need for efficient evaluation of outcomes in children's system of care programs. One of the strengths of the Ohio Scales is the parallel assessment of parent, youth, and agency worker that provides a rich context for understanding changes in youth outcomes over time. The widespread adoption of the Ohio Scales for systems of care evaluation could advance the goal of improving outcomes for children's mental health care recipients.

To assess the full utility of the Ohio Scales, it is important that all the latent information of the items is harnessed. Exploratory factor analyses have been performed that indicate a robust three factor solution for the Ohio Problem Scale (Baize, 2001). These three components, or subscales, have been labeled Externalizing, Internalizing, and Delinquency. The current paper reports confirmatory factor analyses of the Ohio Problem Scale.

Method

In 2001, the California Department of Mental Health conducted an assessment of the utility of the Ohio Scales for outcomes assessment and program evaluation. The pilot package of instruments included the Ohio Scales, the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges & Wong, 1996) and questions covering youth risk factors including past suicide attempts, law violation, gang association, physical or sexual abuse victimization, and exposure to violence.

Data were collected in 15 California county children's mental health programs as part of the California Children's System of Care. The sample contained completed instrument packages for 3,582 agency workers, 2,976 parents, and 1,582 youth respondents aged 12 through 18 years.

Findings

EFA. Exploratory factor analyses were performed on the Problem Scale items and the Functioning Scale items. Factor analyses of the Functioning Scale did not reveal a clear structure. The final extraction method chosen was maximum likelihood with Oblimin rotation resulting in four factors named: Reasonableness, Hygiene, Sociability, and Industriousness. The analysis produced Heywood cases (commonalities greater than one). Significant cross factor loading were evident for 20% of the items of the agent and parent samples, and 10% for the youth sample. In addition, the composition of factors varied between respondent types, and a factor was formed by only two items. Finally, there is one factor for each respondent type that exhibits significant factor loadings on over half the items, suggesting that a general factor might adequately capture the variance. The EFA suggests that the Functioning Scale does not provide a suitable basis for constructing reliable subscales. Further analyses were not extended for the Functioning Scale.

EFA of the Problem Scale items provided a clear three factor solution. The maximum likelihood extraction and Oblimin rotation resulted in three factors with little factorial complexity, named Externalizing, Internalizing, and Delinquency. The three factor solution was robust across the three respondent types, although only three items load significantly on the Delinquency subscale. Cronbach's alphas for the scales are high across all respondent types except for the Delinquency subscale (.70, .62, and .63 for agent, parent and youth respectively).

CFA. Based on the findings of EFA, preliminary Confirmatory Factor Analyses were performed on the Ohio Problem scale. Due to the skewed distribution of many items, particularly the three items of the Delinquency subscale, asymptotically distribution-free estimation was used for the discrepancy function. Separate CFAs for each respondent type revealed that the three factor model is not a good fit to the data, as shown in Table 1 that shows Chi square, Tucker-Lewis Index, Comparative Fit Index, and Root Mean Square Error of Approximation.

Table 1
Chi Square and fit indices

	χ^2	df	p	TLI	CFI	RMSEA	90% CI
Agent	1567	167	<0.0001	.65	.69	.052	.050-.054
Parent	1061	167	<0.0001	.67	.71	.042	.040-.045
Youth	422	167	<0.0001	.72	.75	.031	.027-.035

These fit indices are well below the established criteria for acceptable fit, with the exception of RMSEA which is below .05 for all but agent respondent. Additional analyses in the poster will explore modifications and suggest ways to improve the models.

Utility. The concurrent administration of the CAFAS provided information on the validity of the derived subscales. Consistent with the content domain of the Ohio Problem scale Externalizing subscale, it correlates highly with the CAFAS Role Home and Behavior Toward Others scales for agent respondents ($r_s = .53, .51$) and moderately for parent respondent ($r_s = .34, .30$). Internalizing correlated with Moods/Self-Harm of the CAFAS for all three respondent types ($r_s = .34, .35$, and $.33$). The Delinquency subscale correlates well with the CAFAS Substance Use scale for all respondents ($r_s = .58, .42$, and $.34$). Significant differences were observed on Ohio Problem subscales based on risk factors of prior suicide attempt, gang association, and victim of sexual abuse, among others.

Conclusion

The Ohio Scales attempt to provide a concise battery of measures to address the evaluation needs of children's mental health services and outcomes studies. The Problem scale in particular appears to be reliable and valid. Exploratory factor analyses identify three distinct subscales that extend the utility of the measure. CFA, however, reveals problems. The poor fit of the three-factor model of the Problem scale indicates that there is substantial unexplained variance. A revision of the scale could strengthen its psychometrics and provide a better tool. The brief three item Delinquency subscale should be expanded.

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Poster 3

Ensuring an Equitable Representation of African Americans in Evaluation

Presenting: Ladel Lewis & Carolyn Sullins

Introduction

The Kalamazoo Wraps Evaluation Team is responsible for assessing the effectiveness of “Kalamazoo Wraps,” a SAMSHA-funded initiative aimed at assessing and improving the system of care for youth in Kalamazoo County. About 50% of the consumers at Kalamazoo Wraps are either Caucasian or African American, followed by a very small proportion of other ethnicities. A goal of the Kalamazoo Wraps Evaluation Team is to assure that families of all ethnicities are recruited and retained in the study. Without adequate representation in evaluation, accurate conclusions cannot be made about the effectiveness of this system of care initiative. However, there are numerous barriers to recruiting and retaining African Americans in evaluative studies.

Historical Relationship Between African-Americans and Data Collectors

There has been a turbulent relationship between data collectors and the African American communities throughout history (Blauner, 2001). Some of the main reasons are (1) Results are not disseminated to the community; 2) Results are interpreted out of context; 3) Respondents suspect data collectors are sent from the government to spy on/interrogate them; 4) Respondents inherit suspicions from historical racist actions, such as the Tuskegee Syphilis Experiment and the McCone Commission. As a result, previous generations encourage future generations not to participate in research endeavors; and the current generation chooses not to participate based on their own experiences with data collectors and perceptions of research.

Because of the historical abuse of African-American research participants, it is essential that data collectors are able to earn the trust of their potential participants. Data collectors must avoid using legalistic jargon; at the same time, they must avoid a condescending tone with their participants. According to Stafford Hood and Associates, “If the evaluator isn’t capable of relating to impactees or hiring data collectors to do so, maybe they should avoid conducting evaluations that require direct contact with ethnic populations” (Hood et al., 2005). Cultural Competency and Communication Competency should serve as a criterion for getting hired (Hecht et al., 2003). Last, having a rigorous interview training protocol is vital.

The Kalamazoo Wraps Evaluation Team has worked to reduce the barriers in recruiting African American participants. Scenarios testing cultural competency are interwoven in the data collectors’ training. This helps interviewers establish relationships with participants, and helps them address issues that may come about. Interviewers remind the interviewees of voluntary participation, confidentiality, and the importance of their experiences and opinions. Furthermore, the evaluation team works closely with parents of consumers to interpret the data in the appropriate context. Findings are published on a website and through newsletters. As most participants are below the poverty line, generous gift cards serve as incentives.

Research Questions

Drawing from the literature, two research questions were established: (1) Are African Americans less likely to participate in the Kalamazoo Wraps Longitudinal Outcome study than Caucasians? (2) Is there a relationship between the race of the respondent and the race of the interviewer in recruitment or retention?

Methodology

Measuring How Well our Methods Reduced the Barriers

We compared the caregiver consent/participation rates for African-Americans versus Caucasian participants. Next, we explored whether the match or mismatch between the ethnicity of the interviewer and the ethnicity of the interviewee had an impact on retention. We also collected qualitative data from researchers to determine what worked and what didn’t when interviewing youth and families, particularly African Americans.

Findings and Conclusions

Reducing Barriers: Ensuring Cultural Competence

African Americans make up about half of the entire study, and they are about as likely to participate in the Kalamazoo Wraps outcome study as Caucasian participants. According to the data, there wasn’t a significant relationship between the race of the respondent and the race of the data collector and recruitment or retention. These overall findings indicate that the demographically-diverse Kalamazoo Wraps Evaluation Team has been successful in recruiting African American participants into the national evaluation study.

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Poster 4

Learning Collaborative Metrics as Performance and Fidelity Measurements

Presenting: Keren Vergon, Cynthia Blacklaw, Kelly Stone & Diana Born

Introduction

As part of its participation in the National Child Traumatic Stress Network (NCTSN), the Trauma Recovery Initiative (TRI) Center participated in a Learning Collaborative to study how to implement Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) at both the organizational and clinical levels. TF-CBT is an evidence-based practice shown to be efficacious for youth with complex trauma. The TRI Center has recently completed the first year of a four-year demonstration project exploring the use of TF-CBT compared with standard clinical care in Northwestern Florida with youth in out-of-home care or who are at-risk of being placed in out-of-home care. Adapted from the Institute for Healthcare Improvement's model, the NCTSN TF-CBT Learning Collaborative contains three tracks: one for administrators and evaluators called the "Senior Leader" track, a Clinical Track for clinicians, and a Supervisor Track for clinical supervisors. The Learning Collaborative approach has been successfully used in healthcare, pediatrics, and foster care, and is recognized as an effective dissemination method for best practices. At the beginning of the Learning Collaborative in March 2008, the TRI Center was a new NCTSN grantee and had never offered TF-CBT to its families. The TRI Center chose to participate in the Learning Collaborative in order for: (1) its clinicians to learn TF-CBT from the creators of the evidence-based practice; (2) the Center's leadership to learn how to implement TF-CBT in its organization; (3) the Center staff to learn best practices from other NCTSN Centers across the United States who were also implementing TF-CBT; and, (4) for the Center staff to learn how to use appropriate trauma assessment tools, TF-CBT fidelity instruments, and other support documents developed specifically for supporting the provision of TF-CBT with fidelity.

Methodology

Three clinicians, the clinical program supervisor, the executive director, and evaluator for the grant participated in the Learning Collaborative. The Collaborative held three group meetings (March, June, and December 2008), and monthly Senior Leader, Clinical Supervisor, and Clinician calls led by Learning Collaborative faculty. In addition, individual centers that participated in the Learning Collaborative continually participated in activities directly related to the Learning Collaborative by providing TF-CBT to families, participating in clinical supervision, and implementing Small Tests of Change and other forms of modifications to document attempts to improve service provision. Monthly metrics forms were used to track the number of TF-CBT sessions families received, the number of times clinicians met with caregivers in the context of therapy, treatment status (continuing, completed, or stopped treatment), completion of trauma assessment tools (PTSD-RI and TSCC-A), and perceived expertise in the use of individual TF-CBT techniques. The amounts of consultation with TF-CBT experts and clinical supervision received were also monitored. Data reported from each participating Center in the Learning Collaborative were shared so that centers could identify other centers that could be resources for addressing challenges or improving on successes.

Findings

The TRI Center began participation in the Learning Collaborative in March 2008. At that time the Center completed a self-evaluation of knowledge level about and experience with TF-CBT. No clinicians were providing TF-CBT. By September 2008, about two-thirds of the way through the Learning Collaborative, the TRI Center had four clinicians providing TF-CBT, with three providing TF-CBT to at least three families. Ninety-two percent of the sessions included a caregiver for at least 15 minutes of the session. All seven TF-CBT clinical components were identified as used by clinicians, with mean ratings of degree of use and skills ranging from 1.0-3.2 on a 0-4 scale. The overall mean rating of techniques used to structure TF-CBT sessions was 2.8 on a 0-4 scale. All TRI Center clinicians received at least two hours of TF-CBT supervision each month. Final metrics will be reported in December 2008 at the final Learning Collaborative group meeting. These results will be incorporated into the presentation at the conference in February 2009.

In terms of adoption of trauma assessment tools, fidelity instruments, and related supporting TF-CBT documents, clinicians quickly integrated the trauma assessment tools into their regular practices. A TF-CBT supervision checklist was used for clinical oversight to ensure fidelity to the model, and the TRI Center is experimenting with a TF-CBT technique-specific progress note for documentation purposes. The Learning Collaborative experience has led to the development of a TF-CBT training manual and protocol for new clinicians. The model includes online, self-guided, and face-to-face training; role playing, shadowing and mentoring; and supervision and documentation techniques.

Conclusion

The Learning Collaborative experience has proven to be an intensive, supportive method for the TRI Center to learn and implement a new evidence-based practice in its program. Clinicians have developed competencies in TF-CBT, and the program supervisor has received support and guidance in managing the implementation of an evidence-based practice. Exposure to a variety of TF-CBT supporting document tools and TF-CBT fidelity tools, as well as the Learning Collaborative metrics forms have provided the framework for an ongoing evaluation of the degree of TF-CBT implementation with fidelity in this NCTSN Center. This fidelity study will begin in 2009 after the conclusion of the TF-CBT Learning Collaborative.

Poster 5

High Fidelity, Low Morale: Using WFI-4 Principle and Phase Scores to Assess Wraparound Facilitator Burnout

Presenting: Josie Welsh

Introduction

Recent analyses of challenges to fidelity in wraparound care highlight staff turnover and lack of natural supports as deterrents to fidelity. Rast & Vandenberg (2008) conclude that supporting staff in the wraparound facilitator role will decrease time to fidelity and keep facilitators in their jobs longer. The current study utilized a three-pronged feedback and evaluation system to investigate facilitator morale as it relates to caregiver satisfaction, wraparound fidelity, and phases of wraparound care.

Methodology

The study was part of ongoing local evaluation of Action for Kids (AFK), a system of care currently serving 130 families caring for children with serious emotional disturbances in the Arkansas Delta region. Each of four counties is served by one family support provider and two wraparound facilitators. The system of care receives referrals from mental health (64%), schools (12%), juvenile justice (10%), and child welfare (6%). Wraparound facilitators manage a caseload of 15 families each, and no management information system exists for information exchange between agencies. Facilitators track visits, assessments, plans, team goals, and flexible fund expenditures with paper and pencil tools.

Action for Kids serves children from counties of varied socio-economic backgrounds. One northern county boasts two major hospitals and a university, while surrounding counties host poverty-stricken families whose literacy hovers around a third-grade reading level. Eighty-three percent of the youth are between the ages of 10 and 18; 68% are male.

The evaluation component of AFK interviewed 11 female family support providers and wraparound facilitators, most of whom had worked with AFK for a period of one year. Two of the wraparound facilitators had recently submitted resignation notices at the time of the interviews. Interviews consisted of open-ended questions, such as "Are you spending your time as you thought you would?" and "What is working well in the AFK program?" Responses later were organized according to day-to-day operations, overall vision of AFK, and sustainability.

The second prong of the study consisted of caregivers' perceptions of and satisfaction with family support providers. Twenty-two caregivers were interviewed about their experiences with these family liaisons.

The third prong of the study included a psychometric index of fidelity. The Wraparound Fidelity Index-4 was administered to 69 individuals representing 36 families in the Arkansas Delta. The average time the families had been in wraparound care was eight months.

Findings

Interviews with wraparound facilitators and family support providers found that women in these roles felt encouraged by meetings with other system of care coordinators, easy access to flex funds, and collaboration with youth mentors, tutors, and school coaches from surrounding schools that implemented Positive Behavior Intervention Systems (PBIS) as part of the system of care community. However, all family support providers and care facilitators interviewed expressed low morale evidenced by feelings of isolation, lack of support at the local and state level, productivity demands, and disengaged family members.

Interviews with caregivers indicated that 100% of respondents felt that AFK is worthwhile and should be continued even after the grant runs out. Ninety-five percent of those interviewed said they were very satisfied with the services they received and felt understood by their family support provider. Thus, although the providers themselves felt discouraged, caregivers were very satisfied with the care they were receiving.

Results from the WFI-4 found that overall fidelity of AFK was .80, indicating adequate wraparound care as assessed by caregivers, wraparound facilitators, youth, and team members. Four of the ten wraparound principles, including voice and choice, strengths-based, cultural competence, and persistence reached high fidelity at .85 or higher. Together, data from each analysis suggest that families are satisfied, the program is praised, and fidelity was evident from the planning phase through implementation of AFK. However, two markedly low element scores and two noteworthy phase scores revealed possible explanations for wraparound facilitator and family support provider burnout.

Across all four categories of respondents, the specific elements for community-based and outcome-based failed to reach fidelity of 75%. Outcomes-based was rated as low as 51% by team members. Phase scores also revealed possible explanations for burnout. The transition phase, a time of preparing for natural supports and community-based support to sustain the family, did not reach fidelity according to any of the four groups of respondents. Finally, although youth did report fidelity in the planning and implementation stages (84%), the fidelity for the stage of engagement was markedly lower (75%).

Conclusion

These findings support Rast's (2008) conclusion that system and organizational supports, particularly community supports, are necessary to achieve high fidelity wraparound. The combination of high fidelity scores in areas that rely upon facilitator skill such as including families in decisions (voice and choice), highlighting specific strengths of the family and youth (strengths-based), persistence, and cultural competence, and low scores in areas that integrate the youth into his or her community (community-based) with specific, measurable goals (outcomes-based) can adversely affect morale among key service providers.

Action for Kids has responded to these findings by incorporating data-driven, decision-making tools in wraparound meetings as guidelines for group discussion and family intervention planning. Evaluation team members are training families in evaluation as part of the transition phase of wraparound. Door prizes and holiday baskets are given as incentives for family participation. To encourage outcome-based interventions, the evaluation team has produced individual family progress reports that inform families about specific behavioral outcomes of system of care involvement.

Finally, the evaluation team of AFK has initiated collaboration with the social marketing component of the program to address fidelity and outcomes that, according to Rast (2008), are directly related. It is therefore the goal of stakeholders involved in AFK to wrap around the wraparound facilitators, in order to raise staff morale and minimize turnover.

Reference

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Poster 6

Community Indicators and Systems of Care Implementation

Presenting: Laurel M. Lunn

Contributing: Craig Anne Heflinger, Krista Kutash & Paul Greenbaum

Introduction

The system of care (SOC) approach to mental health care for children with serious emotional disturbances aims for a comprehensive, community-based, integrated system of service providers from multiple arenas (Stroul & Friedman, 1986). This approach is expressed as a “philosophy” about how to deliver services that will differ between communities because of contextual factors. It is important to assess SOC to see which elements are being implemented, which are working successfully, and which to focus on for future assistance. This study will focus on community contextual factors, based on the literature on social and community indicators that influence SOC implementation.

In the 1960s a broad movement began in which it was recognized that the purely economic indicators of national status were no longer sufficient. The social indicators movement aimed to provide information for policymakers and to provide baseline information to aid in setting goals and targets for the future. Many community projects aim to construct a common “vision” of health and indicators are used to detect areas that may need improvement or are strengths of the communities.

There is no consistent agreement among communities, academics, or child research and development agencies regarding which indicators are most salient to child health, well-being, or quality of life; however, there are common threads in indicator systems. Many community factors that have been shown to have effects on children's health or healthcare come from the education, health, family situation, and economic arenas. For example, poverty has been linked to disadvantage in well-being and health (Eberhardt et al., 2001). Less family education, single-parenthood, and black ethnicity have been independently associated with having a lower health-related quality of life (Simon, Chan, & Forrest, 2008). Identification of youth with substance abuse disorders has been connected to higher income, high school graduation, increased drug arrests, increased concentration of treatment facilities, and lower rates of juvenile detention (Jones, Heflinger, & Saunders, 2007). Finally, the Urban-Rural Chartbook (Eberhardt et al., 2001) reported that adolescents in the most rural counties are most likely to smoke, and have the highest rates of death and unintentional injury.

Community indicators can be of great use to us in exploring systems of care. If we discover associations between various indicators and specific elements of system of care implementation, then we can determine which community factors have enhancing or resisting effects on these systems. We can then make efforts to improve technical assistance to communities or to target communities which are struggling with information about what conditions can be targeted or how to promote the system more effectively.

Methods

This study is a secondary analysis of a national survey to assess system of care implementation, the System of Care Implementation Survey (SOCIS), developed by the University of South Florida's Research & Training Center for Children's Mental Health to document issues regarding implementation of systems of care in communities. Fourteen implementation factors related to systems of care were identified by the SOCIS, based on review of SOC literature, consultation with researchers, parents and professional leaders, and surveying state mental health directors. Survey items and operational definitions were developed by expert teams, review by an expert panel, cognitive interviewing, and pilot testing. Multilevel confirmatory factor analysis suggested that seven of the fourteen factors had statistical validity

in explaining the variation in mean response between counties (Greenbaum, Wang, Kutash, Boothroyd, & Friedman, 2008). These seven factors will serve as the dependent variables in this study and are: Family Choice & Voice, Outreach & Access to Care, Transformational Leadership, Local Population of Concern, Interagency & Cross-Sector Collaboration, and Comprehensive Financing Plan and Provider Accountability. Independent variables in the data set include SOC grantee status, respondent characteristics, and respondent self-reported knowledge about local mental health services.

Sample. In the SOCIS, 225 counties were stratified by poverty and population size. Within counties, survey respondents were selected from the following sectors: Mental Health, Education, Family member/advocate, and Other child-serving sector. A total of 910 respondents were nested within the 225 counties.

Other Data Sources. Community indicators (estimated at the county level) to be used as independent variables in the analyses include percentage of county considered rural, presence of a community health center, percent of the 5-15 year-olds in the county with a mental disability, and factors representing crime, economic advantage, economic disadvantage, high immigration, and residential stability. These data come from secondary sources including the 2000 decennial U.S. census, the most complete source of data which are representative at the county level.

Data Analysis. An initial bivariate analysis will create county-level mean scores and investigate association between SOC implementation rating and rurality (rural v. urban) of the county in which the SOC is embedded. The multivariate analysis will examine the associations between SOC implementation factors and a variety of community indicators described above, including rurality.

Findings

These analyses found that community factors predicted at least ten percent of the variation in three of the SOC implementation factors (Family Choice & Voice, Outreach & Access to Care, Interagency Collaboration). Rurality was significantly associated with lower SOC implementation in each of these SOC factors, while higher proportions of children with disabilities was positively related to them. Two other community variables, residential stability and crime, were also positively related to two of these three SOC factors. More research is needed to determine the mechanisms involved in these relationships. It is likely that higher prevalence of certain community characteristics that child-serving sectors deal with frequently, like crime, effects a mediator variable which explains the predicted changes.

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Poster 7

Real World/Real Time Performance Measurement: Supervision Strategies to Enhance Systems of Care Outcomes

Presenting: Katherine Grimes & Sophie Lehar

Introduction

Those of us fortunate enough to work with youth and families in systems of care (SOC) know that the first priority is creating a connection. That connection, at times slow to kindle due to a family's difficult earlier experiences with "services," gets you in the door, and, if all goes well, allows caregivers and their children to speak openly about their strengths and needs. Getting this far may, in itself, be an accomplishment, given multiple barriers to engagement, but it represents only the beginning of the process. Like the old joke about "too much month at the end of the money," SOCs may find themselves coming up short at evaluation time due to how teams, Care Managers and Supervisors have spent their time and resources, despite everyone's best efforts.

Advocates have emphasized the need to develop new indicators that can drive quality in areas such as juvenile justice and cultural competence (Cocozza, 2000; Isaacs, 2005). Sonia Schoenwald and others have addressed this need with regard to systems of care more than once, referencing results obtained via the highly manualized Multi-Systemic Therapy process (Schoenwald, 2000), as well as stressing the importance of clarity and consistency in what is being taught during dissemination and transport efforts (Schoenwald, 2001).

Objective

Increase familiarity with supervisory strategies, including accessible and applicable performance measures, designed to offer critical support to supervisors in guiding complex SOC processes toward best possible outcomes.

Method

The poster will describe methods for bringing "evaluation" closer to home for clinical staff, planning measurement that can happen within a clinically useful time frame, and developing accessible ways to provide support for supervisors so that performance measurement works for us rather than the reverse.

The focus will be on how to build-in process protections for clinicians and supervisors and guidance for teams so that their selected interventions are maximally effective in impacting prioritized goals. Examples of tailored processes will include the effort made by Drs. Eric Daleiden, Bruce Chorpita, et al. to itemize both child status and system level quality indicators (Daleiden, 2006) and the new measure, the SOC Practice

Review (SOCPR) protocol, developed by Drs. Mario Hernandez, Angela Gomez, et al., designed to capture the degree to which system of care practices are adherent to principles of systems of care (Hernandez, 2001). Using an interactive process, poster attendees will have the opportunity to identify: (1) priority issues for clinical supervision in systems of care, (2) common "real world" challenges faced by both SOC Supervisors and Care Managers that interfere with practice fidelity, and (3) experience-based suggestions for addressing supervisory needs and promoting continuous quality improvement within systems of care. Attendees will also be asked to propose practice-focused performance management processes that would assist them in the training and quality management of clinical staff. Interested volunteers will have the opportunity to contribute ideas regarding future development of an interactive website targeted for supervisors and system of care advocates.

Who Should Participate

This poster is intended for direct service providers, their supervisors and managers, family members, policy makers, researchers and educators.

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Poster 8

Family Driven Flexible Funds: Using Technology to Improve Systems

Presenting: Rebecca Robbins, Harriet Scott & Karen Maziarz

The ASO Story

In 2003 the Children's Board began using a financial management tool called the ASO (administrative service organization). Initially funded through a system of care grant from CMHS, the ASO was designed by families, providers and funders to increase family choice and improve outcomes by using flexible funding to purchase services and supports identified and directed by families. The long term vision was to create a system-level structure that provided "value-added" benefits for families, funders and the community.

Families wanted to be able to identify, direct and purchase a wide array of services and supports using multiple funding streams across multiple systems. In addition, families wanted the system to be responsive and wanted assurance that providers with whom they engaged were qualified and respectful. Providers wanted a way to procure high quality non-traditional supports and services identified by families with efficiency and without duplication. Funders wanted to maximize revenue and wanted better coordination. Reducing administration costs and increasing accountability was also a goal. Community stakeholders wanted outcomes that showed that families had immediate access to supports and services that would appropriately address concerns and prevent the need for more costly interventions later on.

Over the past two years, new training, accountability and financial management systems supporting the ASO infrastructure have enabled the Children's Board to realize this long term vision. With expanded collaborations and new funding partners, the ASO is now addressing emerging community needs and new target populations with increased accountability and lower cost.

This poster will focus on the three new aspects of the ASO developed over the past several years: (1) training and technology that continually reinforce the values of family-directed systems of care, resulting in extension of family-directed wraparound planning to new systems and target populations; (2) accessible and easy to use technology to provide "real-time" accountability that supports data-based decision making by families, providers and funders; and (3) state of the art, cross-system funds management and benefits coordination, allowing families to choose services paid by multiple systems with ease and efficiency, while allowing providers and funders to be accountable for every dollar expended at no additional administrative cost.

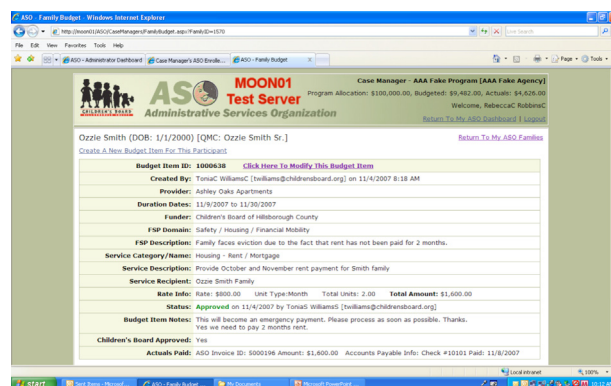
From 2003 to 2007, the ASO was managed by a Boston based firm with a locally-based coordinator. Last year the Children's Board developed the internal capacity and a customized web application to support the ASO, dramatically reducing administrative overhead. Families, case managers and funders were integral in the development of this state-of-the-art management information tool. In addition, three new funding partners have invested in the ASO flexible funding pool: the United Way, the Department of Children and Families—Children's Mental Health, and the Department of Children and Families—Title XXI. The Children's Board continues to provide support for the administrative functions for the ASO as an investment in the infrastructure of a comprehensive system of care in Hillsborough County.

The ASO model requires a philosophical transformation to true partnership with families; this shift in philosophy and practice takes time and ongoing support from supervisors and other case managers. On-line training and other coaching supports are provided by the Children's Board and other funders, and as new programs and agencies are identified, the wraparound philosophy is being increasingly accepted as effective and worthwhile for all involved.

Over time, the ASO expanded to serve additional target populations, including young children and their families and child welfare programs and families facing homelessness. In FY 08, the ASO served 2818 children and their families, and payments were made to over 1000 different providers/vendors. At this time, nearly 300 case managers employed at 53 agencies can access flexible funding from four different funding streams. The ASO budget for FY 2009 is \$2,165,000. The Children's Board currently funds 56% (\$1,386,905) of the total budget.

Expanded Uses of ASO

During the life span of the ASO, spending for housing and housing supports increased from 11% of the total budget to 48% of the total budget. The shortage of affordable housing and rising rates of evictions and family homelessness led to the formation of a community partnership and creation of a "virtual case management" system using email and electronic referral with timelines for partners to provide immediate response to families in crisis. In addition, three programs in three geographically diverse areas were allocated funds for case management. After careful analysis we recognized that giving a working family a "hand-up" versus a "hand out" would require easy access to an assortment of traditional and non-traditional services and supports (e.g., housing, employment, child care, training, education, financial literacy, reliable transportation) for a long enough period of time to create sustained stability and system independence. The ASO was selected as the mechanism to purchase and reimburse those services and supports identified by families who were facing homelessness.



Accountability

Children and their families are enrolled in the ASO by their case manager. The case manager develops an Individual Budget with the family, based on the needs and goals expressed in the Family Support Plan. The Individual Budget becomes the 'payment authorization' for the ASO, allowing the ASO to contract with providers and pays for authorized services. The ASO reimburses providers based on a weekly payment schedule and makes emergency payments within one business day, as needed.

Accountability and responsibility of funds in the ASO is managed on multiple levels. Monthly management reports provide detailed information about how funds are utilized, and which providers and vendors were reimbursed for the services and supports. Family Financial Reports can be produced in multiple languages and are mailed directly to families. Real time information is available to case management programs and funders through the web application about funds allocated, funds budgeted and actual payments, which allows for month to month oversight and analysis of resources purchased.

Poster 9

Perspectives of Treatment Foster Parents on Transitioning Youth to Family Settings

Presenting: Karen Castellanos-Brown & Bethany Lee

Introduction

With concerns about the costs and limited evidence supporting the effectiveness of group care placements (Barth, 2002; Epstein, 2004; Hair, 2005; Wells, 1991), there has been increased interest in transitioning youth from residential treatment or other group settings to less restrictive evidence-based services, such as treatment foster care (TFC). TFC is one of the fastest growing types of residential placements for youth (Hussey & Guo, 2005; Farmer, Wagner, Burns, & Richards, 2003). Despite the interest in TFC and efforts to step down youth from more restrictive settings, no studies could be found that incorporate youth or treatment foster family views on planning for these transitions. This study sought to gather knowledge from treatment foster families to inform transitions to less restrictive settings. Specifically, this study addressed the following research questions: (1) What do TFC parents need to know and want to know about these youth to maintain them in their homes? and (2) What can agencies do to ensure a smooth transition and stable placement? Results from this study use TFC parent perspectives to guide “best practices” in moving youth to lower levels of care and preparing paraprofessionals like TFC parents to care for challenging youth with mental health needs in family settings. The purpose of this presentation is to inform practitioners involved in systems of care of the best practice implications that emerged from this qualitative study.

Methodology

With funding from the Christopher O’Neil Foundation, 20 interviews were conducted with 22 TFC parents involved with the Woodbourne Center in Baltimore, a private social service agency providing a continuum of placement services for youth from several public systems, including child welfare, mental health, and juvenile justice. TFC parents completed in-person unstructured interviews that lasted between 21 and 53 minutes ($M = 32$ minutes). All participants lived in Baltimore City or a surrounding Maryland county. Most of the time, the interview was completed by an individual TFC parent. Twice, married couples who worked together as TFC parents participated in the interview.

SPSS 15.0 was used to obtain descriptive statistics for the sample of TFC parents. Respondents reported TFC parenting experiences ranging from less than 1 year to 20 years ($M = 6.5$) and having fostered 1 to 13 ($M = 4.9$) kids. All TFC youth received individual mental health counseling and some treatment foster parents participated in family therapy sessions with the youth.

For the qualitative interviews, content analyses of transcripts were used to identify themes in participants’ interviews. Coders initially read through the transcripts multiple times to identify consistent themes raised by participants and develop a codebook. Using the codebook, coders separately conducted line-by-line coding of 20% of the transcripts and then reconvened to compare codes and make changes to the codebook. Another 20% of the transcripts were individually coded and results were compared, from which the final codebook structure emerged. All the remaining transcripts were double-coded and results were compared.

Findings

This study found three key phases in a youth’s transition to a family setting. “Getting acquainted” involved meeting the youth and assessing their fit in the home. One TFC parent said that she knew from the visit that the placement would be successful: “He came right in and blended right in with the family. It was like he was part of the family and I liked that.” “Getting settled” described efforts to connect youth

with school and mental health services in their new family setting. Transitioning youth to new mental health providers was facilitated for most TFC parents by referrals to providers near the TFC home provided by Woodbourne’s TFC social workers. For example, one respondent mentioned, “They get them connected with a lot of services... She came already with therapeutic social work services.” Finally, the “getting adjusted” phase included TFC parents’ recounting evidence of a successful transition or identifying concerns that led to placement disruptions.

Conclusion

Results from this study are relevant to agency administrators, group care staff, and TFC workers who are interested in improving youth transitions from group care to family care. Several suggestions for improving youth transitions came out of this study.

These best practice suggestions include that:

- TFC administrators should build relationships with related systems of care that serve youth to improve TFC parents’ access to up-to-date background information on youth.
- TFC administrators should provide adequate opportunities for pre-placement visits.
- TFC administrators should consider developing a clothing bank or partnering with local clothing retailers in the community to provide basic clothing items for incoming youth.
- TFC agencies should provide ongoing training to TFC parents.
- TFC workers should be encouraged to pro-actively support TFC parents, particularly during challenging times when placement stability may be in jeopardy.

By incorporating some of the best practices identified in this study, TFC providers, as well as group care providers, may be able to improve the quality and effectiveness of services delivered to this challenging population. Future research should include the voices of youth transitioning from higher levels of care to increase understanding of their perspectives of this experience.

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Poster 10

Special Needs Adoptive Children: A Compelling Case for Long Term Cross-System Collaboration

Presenting: David Hussey

Introduction

In fiscal year 2007, the number of children waiting to be adopted was approximately 130,000 (U.S. Department of Health and Human Services, 2008). These children represent a significant portion of children served by the public child welfare system, yet we know surprising little about them beyond the broad and limited case level information routinely gathered through the Adoption and Foster Care Analysis and Reporting System (AFCARS). A more in-depth analysis of domestic adoptee characteristics and mental health needs will inform cross-system service planning.

Methodology

Three hundred and sixty two consecutively referred adoptive cases from a single agency were analyzed with adoption placements ranging from 2/22/97 to 4/17/2005, coinciding with the implementation of the Adoption and Safe Families Act (PL 105-89). Exhaustive chart reviews were conducted using detailed and specific operational definitions for over 200 study variables. A subset of variables that featured most prominently in analyses was selected for interrater reliability analyses. Reliability was calculated at multiple time points in order to determine if adjustments were needed to clarify coding definitions. Moderate to high rates of interrater reliability were achieved, ranging from .52 to 1.00, with an average reliability score of .86.

Findings

Child characteristics

The children referred for adoption were equally split by gender, 181 were male and 181 were female. The average age of the child at the time of adoption placement was 7.5 years-old ($SD = 4.12$), and 80% of the children were referred from Cuyahoga County, Ohio. The majority of the children were African American, 233 (64.4%), followed by Caucasian, 102 (28.2), Asian or Pacific Islander, 20 (5.6%), and biracial 6 (1.7%). After careful review of the client charts, 173 or 47.7% of children had clear documentation of prenatal exposure to maternal alcohol or drug use, or related toxins.

Child maltreatment

There were 19 maltreatment categories covering various types and interactions of physical abuse, sexual abuse, emotional abuse, and neglect, including medical and educational neglect. For the 254 children who had clear documentation of child maltreatment, neglect was the primary or most common type of maltreatment affecting 54.7% of children. Over a third, or 38.2%, of children had experienced multiple types of maltreatment including 9.8% who had experienced neglect in combination with physical and sexual abuse. In addition to maltreatment, 68 children (18.8%) experienced a significant interpersonal loss through death. The most frequent loss was of a biological sibling ($n = 20$, 5.5%), followed by a parent, either a father ($n = 14$, 3.9%) or mother ($n = 13$, 3.6%). Seven children (1.9%) experienced the death of their foster parent, and five children (1.4%) experienced multiple deaths.

Primary diagnosis at intake

Out of 362 clients, 310 (85.6%) received a DSM-IV intake diagnosis. The remaining 52 clients (14.4%) were undiagnosed typically due to their young age (i.e., infants) or lack of clinical impairment. Of those who received intake diagnoses, the most frequent diagnoses were V-Codes

for Child Neglect, Physical/Sexual Abuse of a Child (29%), followed by Adjustment Disorder (22.9%), Relational Problems (11.9%), Attention Deficit Hyperactivity Disorder (ADHD) (10%), and other disruptive behavior disorders (5.8%). Approximately 6.8% of children had intake diagnoses of Post Traumatic Stress Disorder (PTSD), and another 6.1% had diagnoses of Reactive Attachment Disorder (RAD). In addition to DSM-IV mental health diagnoses, information regarding developmental disabilities, handicaps, and delays was also extracted. Approximately 126 or 34.8% of children had documented developmental, learning, or speech disabilities and delays.

Biological family characteristics

The mothers on average were 31.6 years of age when they lost custody and had approximately 5.0 children ($SD = 2.33$). Substance abuse dominates the lives of these women (78.6%), all too frequently interspersed with periods of homelessness (42.6%) and domestic violence (18.3%). Intergenerational abuse is also evident, with 61 or 16.8% of biologic mothers having their own documented history of abuse and/or neglect as a child. Additionally, 37.5% ($n = 136$) of biological mothers had a documented history of a mental health disorder, suicidal behavior, or unspecified mental health issue noted in the chart documentation. By far, the most common diagnoses were mood disorders, frequently in combination with other disorders.

Over a quarter of the children, 96, (26.8%), had a mother with a history of incarceration. This includes the 9.9% of children who had both parents incarcerated. Based on all available chart review information, approximately 158 or 43.6% children, had a parent, either mother or father, who had a history of incarceration.

Conclusion

Clearly, the youth in this study have significant histories of interpersonal loss (18.8%), victimization, and maltreatment including high rates of multiple maltreatment experiences (38.2%). Such detailed and comprehensive maltreatment histories may not easily be compiled by adoption or foster care staff or well-translated to adoptive parents. It's important for adoption workers to be aware that multiple patterns of neglect and abuse may be more common than documented, and that this historical information is used to identify and guide trauma-informed care.

Profile information on biological mothers indicates that mothers experienced high rates of clinical comorbidity within and across mental health and substance abuse disorders. Given strong biologic and genetic predisposition tendencies to mood and substance abuse disorders and the high rates of prenatal drug exposure (47.7%), early and ongoing monitoring and prevention programming is strongly indicated for special needs adoption children. Adoptive parents need to be aware of developmentally sensitive periods for increased risk of substance abuse initiation and onset of mental illness, and assisted in finding evidence-based prevention programming.

In summing the major child and biological mother risk factors chronicled in this study (i.e., child neglect + child physical abuse + child sexual abuse + child prenatal drug exposure + child positive toxicology screen at birth + maternal mental illness + maternal substance abuse + maternal homelessness + maternal history of domestic violence + parental incarceration + and death of a significant person) youth averaged 4.7 ($SD = 1.61$) risk factors not including poverty, multiple placement disruptions, and other potential risk factors not documented or reported here. In this sample, cumulative risk appears to be the norm, not the exception. Certain clusters of cumulative risk variables (e.g., prenatal

drug exposure, maternal history of mental retardation or developmental disabilities, homelessness, etc.) help to explain the high levels of neurocognitive deficits and developmental delays (34.8%), and herald the need for strong, ongoing collaboration with schools and special education personnel, including teachers, occupational therapists, nurses, tutors, and speech and language therapists.

Poster 11

Engagement of Non Resident Fathers in Child Welfare

Presenting: Myles Edwards & John Fluke

Contributing: Sonia Velazquez

Introduction

The Quality Improvement Center on Non-Resident Fathers (QIC-NRF), a project of the Federal Children's Bureau, performed an extensive literature review and qualitative study of non-resident fathers (NRF) in child welfare. Identification, location, contacting and engagement, as established by the Urban Institute (2007) "What about Dads" report of NRF were organizing issues of the methodology. This project addresses a central role that child welfare participants in a system of care can play in the inclusion of fathers and paternal families in services for foster children. This presentation also identifies substantive and methodological issues in the development of evidence related to father engagement.

Methods

The purpose of the QICNRF is knowledge development and systems improvement. Adoption of the Institute of Medicine framework for knowledge development (qualitative studies, quasi-experimental, small scale random control trial (RCT) studies, and large scale studies) lead to consideration of small-scale RCT under nearly ideal conditions as an appropriate methodological focus to address contact and engagement.

Qualitative results were compelling about the importance of the topic and a focus on contact and engagement. Of eighty key informant interviews, about three quarters addressed contact and engagement with fathers as barriers to father participation. QIC NRF team facilitated or co-facilitated numerous focus groups including:

- Fathers (Philadelphia Fatherhood Festival),
- Fathers (the Dad's Show—Radio broadcast),
- Youth (Independent Living Youth Retreat,
- Fatherhood Program Staff,
- Child Welfare Agency Staff,
- Legal Professionals,
- Program Sub-Grantees,
- Domestic Violence Specialists (via phone, 5/25/07).

These focus groups underscored the importance of involving fathers from the beginning (i.e., at birth). The largest obstacles to father involvement are meaningful engagement of fathers and lack of systemic collaboration. Other issues were:

- Focus groups underscored the importance of involving fathers from the beginning (at birth)
- The largest obstacles to father involvement are meaningful engagement of fathers and lack of systemic collaboration
- Mothers are "gatekeepers" – Maternal resistance due to conflict with father
- Fathers fear the child welfare system

In two large meeting sites, approximately 2/3 of participant statements ($N = 189$ of 338) described barriers. Of the 189 barrier

Reference

U.S. Department of Health and Human Services, Administration for Children & Families (2008). *Trends in foster care and adoption—FY 2002-FY 2007*. Accessed September, 29, 2008 at http://www.acf.hhs.gov/programs/cb/stats_research/afcars/trends.htm.

statements, engagement was cited most frequently. Cross system issues related to legal and child support came up frequently. This resulted in the QICNRF adding "Cross System Issues" to the end of the Identification, Location, Contact and Engagement framework. Those results led to a contact and engagement focus for a four site random control trial study with IRB approval. Initial results focus on the contact, recruitment and initial engagement of NRFs. Incidence of NRF in the out-of-home placement population across states, and safety and permanency outcomes of children with NRFs compared to other children as baseline outcomes.

Recruitment of sites to participate in a RCT experiment to assess the father engagement strategies took on a national scope. A replicable program of systematic father contact and facilitated peer support intervention to help Dads navigate the child welfare and child support systems was developed. The facilitated part of the intervention was specifically intended to address the cross system issues by providing information on how things work and giving Dads problem solving opportunities. Requests were made of jurisdictions, which had some evidence of attention to fatherhood issues, to submit applications to be part of a national study. The child welfare authority of the jurisdiction had to be the lead agency. Four sites were selected, one each in Colorado, Indiana, Texas and Washington State.

Recruitment of fathers in sites is based upon an initial assessment of appropriateness. Concerns of safety can be evidenced by restraining orders or caseworker concerns about the appropriateness of father contact. "Unsafe" fathers are to be excluded.

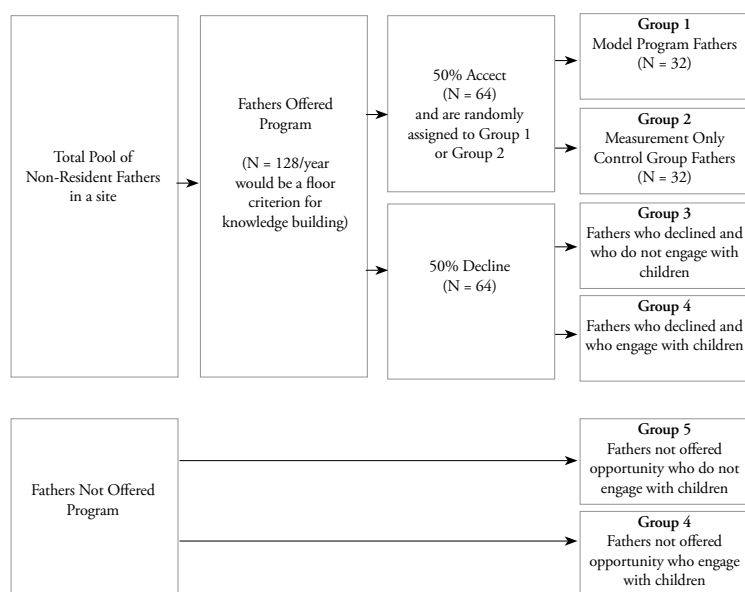
Baseline information on non-resident fathers (NRCFs) was developed from the National Child Abuse and Neglect Data System (NCANDS) and the Adoption and Foster Care Analysis and Reporting System (AFCARS) for participating states and others. This will allow a full design to address site selection issues, reactivity of recruitment, comparability of experimental and control groups and comparative changes over time. Figure 1 on the next page shows the full design with the six groups for whom baseline data can be assessed.

The recruitment of fathers is based upon a child entering out-of-home care. This allows identification of the subset of fathers for whom participation in services is a key issue. This is a role child welfare is uniquely positioned to address due to its responsibility to all parents of children in care.

Of children who had been in placement, safety results from two of the four states show the highest recurrence rates are for children of single female households. Children from households of unmarried caregivers are predominantly living mother. These children had the worse safety outcomes. These results will be extended to other states with inferential tests of significance. These data address the vulnerability of children in these families after reunification.

In addition to safety results, permanency baseline comparisons will also be examined. These results from AFCARS have several composite measures of permanency. Of interest will be the length of stay, reunification and time to reentry outcomes.

Figure 1
NRF QIC Research Design—Site Specific Father Recruitment



Status and Implications

AFCARS results allow examination of length of stay for children of single mothers compared to married couples. These results show significantly longer stays for single mothers. An example of exit status from one state has shown that there were twice as many children of single mothers in an entry cohort. These children of single mothers had lower but not significantly different reunification rates than children of married couples. Return to care rates for one state did not show expected differences, either. These results will be extended to other states.

Recruitment information will be of primary interest in this presentation. Proportions of NRFs appropriate for recruitment will be presented for the four sites. Process flow of father contact, appointment setting, appearance for appointment, agreement to informed consent recruitment, and appearance at first group session are of interest as necessary conditions for father engagement. Differences in baseline information between the sites will be used to address differences in recruitment results.

Poster 12

Non-Kin Natural Mentoring Relationships among Transitioning Foster Care Youth

Presenting: Michelle Munson & Susan Smalling

Introduction

Research has revealed the poor young adult outcomes of transitioning foster care youth (See Courtney & Heuring, 2005 for a review). Yet we know little about how to help these youth during the transition to adulthood. One suggestion is to nurture natural mentoring relationships. A recent study found that older youth in long-term natural mentoring relationships had more positive psychosocial outcomes than those reporting no mentor in their life (Munson & McMillen, in press). Research is now honing in on understanding the nature of these relationships. Greeson and Bowen (2008) found that trust, love, caring and experiencing a mentor "like a parent" were salient relationship characteristics among seven female foster care youth. This poster builds upon these results.

Method

The present study is part of a larger study of 406 older youth from Missouri who were interviewed nine times between their 17th and 19th birthdays. Data collection occurred between December 2001 and May 2003. Fifty-six percent of the sample was female, and 57% were youth of color.

Data for the present study were obtained during the final interview when participants were nearing their 19th birthday Youth who had a natural mentor ($n = 193$), defined as "an adult who is older than you, and is willing to listen, share his/her own experiences, and guide you through some part or area of your life" were asked: (1) what makes this adult easy to relate to; (2) can you give me an example of what makes this person easy to relate to; (3) what do youth think makes them someone that you choose to listen to; and (4) can you give me an example of some advice that your mentor gave you that you listened to?

ATLAS.ti qualitative software and grounded theory coding techniques, with multiple coders, were utilized in the study. The categories, relationships among categories, and quotations make up the results of the study.

Results

Types of adults

The most common types of adults that mentors reported were "staff at placement or former placement" and "friend of the family." However, caseworkers, teachers, therapists, clergy, foster parents and neighbors were also frequently reported.

Qualities of the relationship

Salient qualities such as "she is caring towards me," he/she is "easy to talk to," "I trust him," "she doesn't judge me," and "he is like a father" were indicted often. Youth emphasized listening, suggesting they perceive that some adults do not really listen, "he actually seems to listen when you talk to him." Comments about mentors being direct and not "beating around the bush" were common. One youth reported, "she doesn't substitute words to make it sound like the right thing to say. She just says it." Similar to Greeson and Bowen (2008), youth often reported that mentors were like parents to them, "...[she] is like a mother I never had."

Having things in common

Youth reported "we have chemistry," and "[we] both know how to sing in church choir." These comments suggest older youth are attracted to mentors who like similar activities that they like.

Being known

Youth reported that adults are easy to relate to when they have been around for awhile; for example, "I have been knowing her since I was nine." Older youth often move from placement to placement, which

may intensify the value placed on stability in relationships and knowing someone over time. Another layer of being known was revealed through comments suggesting that knowing mentors over time allowed youth “really know me,” or “know me for who I am.”

Helps me see

Older youth talked about mentors that have helped them see difficult aspects of their lives, for example, a clergy member “...made me see that my adoptive mom could see how bad my biological family was, she was not making it all up.” In certain cases, these mentors helped youth deal with extremely difficult realities.

Understands because he's been there

One of the most common responses was that mentors understand because they have “been there.” Youth reported, “...we have both dealt with mental problems,” and “...she went through adoption and foster care like I did.” It was significant that mentors had “gone through a lot of the same things” as did the youth.

Types of advice

Mentors most often provided advice on school, “get your GED” or “go to college.” Mentors also provided relationship advice, “...two months ago I got beat up by my boyfriend and I wanted to go back to him and she told me not to.” Also, youths reported their mentors gave advice on persevering, “...don't let none of that stuff get you down, keep your head up.” Advice was also given about parenting, avoiding drugs, and managing money.

Poster 13

Juvenile Justice System Involvement and Recidivism among Youths Placed in Out-of-Home Care

Presenting: Svetlana Yampolskaya & Mary Armstrong

Introduction

Prior research has demonstrated higher prevalence of mental health problems among youth involved with the juvenile justice system (Abram, Teplin, McClelland, & Dulcan, 2003; Garland et al., 2001). Furthermore, studies also have shown that youth with mental health and substance abuse problems are likely to become involved in the juvenile justice system. For example, results of a study by Cropsey, Weaver and Dupre (2008) indicated that having a diagnosis of childhood disruptive disorder and use of cocaine were significant predictors of juvenile justice involvement among psychiatric hospitalized adolescents. Similarly, Huizinga, Loeber, Thornberry, and Cothorn (2000) showed an association between the presence of mental health problems and serious delinquency. Other researchers have found that serious mental health problems, and, specifically, conduct disorder, were significant predictors for recidivism. However, little is known about specific diagnoses that predict both the initial juvenile justice placement and subsequent recidivism among maltreated children removed from their homes. This study examined factors associated with the first juvenile justice involvement and subsequent recidivism among children placed in out-of-home care.

Method

Participants were youth, aged from birth to 18 years ($M = 7.41$, $SD = 5.31$); 49% of the sample were male, and 37% were African American, followed by 53% Caucasian, 9% Hispanic, and 1% Other. Data obtained from the Florida Child Welfare Information System and Florida

Discussion & Conclusion

These data further our understanding of what qualities are important to transitioning foster care youth with regard to natural mentoring relationships. The study is limited to youth in one Midwestern state; however, the sample is large and consists of both males and females. Similar to Greeson and Bowen (2008), our results suggest that caring and being “like a parent” are important qualities in these relationships. Findings also suggest the importance of feeling understood, which youth attribute to being known and having been there. Further, mentors provide youth with advice in many areas salient to successful transition, along with “helping them see” difficult realities of their past. These data can be utilized to inform programs geared toward nurturing natural mentoring relationships among older youth exiting foster care.

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Medicaid claims included all children who entered out-of-home care in FY 2004-2005 ($N = 17,329$). The study design consisted of a longitudinal analysis with 24 months follow-up. Predictors included child demographic characteristics, family structure, number of out-of-home placements, and DSM-IV mental health and substance abuse diagnoses. Cox regression (Cox, 1972) was used to examine associations between various predictors and time-to-first-contact with the juvenile justice system. Logistic regression was used to estimate the probability of recidivism.

Results

Multivariate Cox regression indicated that boys were 60% more likely to become involved with the juvenile justice system compared to girls (odds ratio [OR] = 1.60, $p < .01$). Each additional out-of-home placement (OR = 1.13, $p < .001$) corresponded to a 13% increased likelihood of contact with juvenile justice; being one year older corresponded to a 45% increased likelihood of having this experience. When mental health diagnoses were examined, children with conduct disorder were six times more likely (OR = 6.39, $p < .001$) to become involved with the juvenile justice system and children with attention deficit disorder were almost three times more likely (OR = 2.75, $p < .001$) to have this experience (see Figure 1). Additionally, children with substance abuse problems were more than two times more likely to have contact with the juvenile justice system (OR = 2.24, $p < .05$). Race/ethnicity and family structure were not found to be related to delinquency. Results of the multivariate logistic regressions indicated that older youths (OR = 1.34, $p < .001$) were more likely to get arrested and placed in a juvenile justice facility a second time. Compared to Caucasian

and Hispanic children, African American youth were more than twice as likely to recidivate ($OR = 2.12, p < .01$). Children who had multiple out-of-home placements also were more likely to be re-arrested ($OR = 1.16, p < .001$). Finally, youths diagnosed with conduct disorder were more than five times more likely to recidivate ($OR = 5.56, p < .001$), and youth diagnosed with attention deficit disorder were more than twice as likely to return to the juvenile justice system ($OR = 2.14, p < .05$).

Conclusions

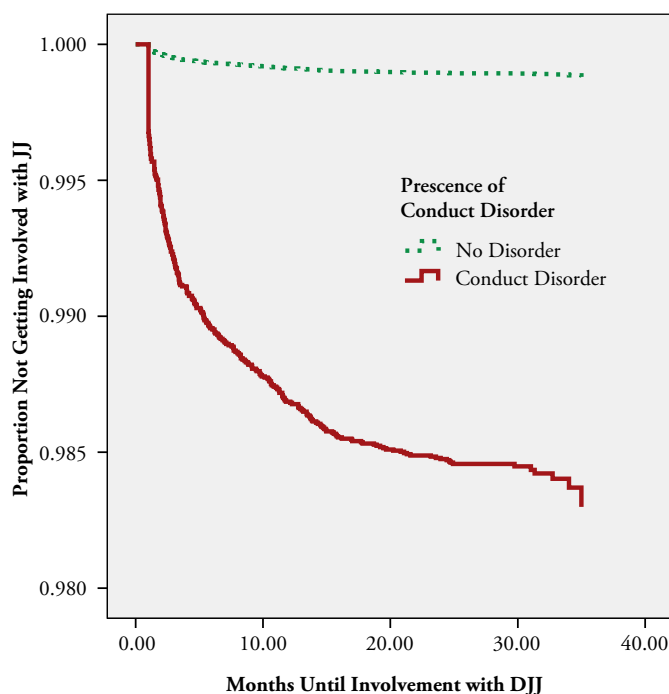
Findings from this study suggest that among youth placed in out-of-home care, the presence of either conduct disorder or attention deficit disorder contribute to chronic involvement with the juvenile justice system. Similarly, a greater number of placements in out-of-home care significantly shortened the time to first involvement with juvenile justice, and is associated with chronic involvement with the juvenile justice system. Depression, bipolar disorder, and posttraumatic stress disorder were not found to be associated with juvenile justice involvement.

These findings also have important implications for service delivery among children who use multiple-service systems. In particular, because previous studies have documented a high prevalence of mental health problems among children placed in out-of-home care (Burns et al., 2004; James, Landsverk, Slymen, & Leslie, 2000), and because our findings indicated that the presence of behavioral problems predict involvement with juvenile justice, it is critical that child welfare agencies work in partnership with mental health and juvenile justice systems to reduce child incarceration. Further, child welfare agencies should develop specific interventions targeted for children who have diagnoses of conduct disorder and who experience multiple placements. Finally, study results suggest that additional supports for foster parents who take care of youth with behavioral problems may reduce future placement changes for these children.

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Figure 1
The Effect of Having Conduct Disorder on Involvement with Juvenile Justice



Poster 14

Evaluation of Youth Functional Outcomes in Maryland's Group Homes

Presenting: Sharon Stephan, Jennifer Mettrick, Wai-Ying Chow, Kevin Keegan & Christina Von Waldner

Introduction

This poster presents findings of a recent evaluation of psychosocial functioning among 180 youth residing in Maryland group homes. The primary focus of the evaluation was to provide Maryland's Department of Human Resources (DHR), which is responsible for the state's child welfare services, with a description of youth residing in group homes and predictors of functioning during group home care. To date, little research exists regarding the types of residential care approaches that work best for different levels of need (Whittaker, 2000). Youth are placed in group care for various reasons such as removal from unhealthy home environments, relocation from other group homes or unsuccessful foster care placements, or removal from residential treatment facilities (Strack, Anderson, Graham, & Tomoyasu, 2007). However, formal placement guidelines in Maryland have not yet been established to match varying levels of services to the diverse needs of entering youth. To that end, Maryland's DHR contracted with the University of Maryland Baltimore (UMB) to study youth currently served by group homes and predictors of youth outcomes, including length of stay, level of need, and demographic characteristics. Maryland's DHR is committed to practice improvements throughout the system and is particularly interested in developing criteria for group home placements. Findings from the current study will inform the development of formal placement guidelines and ultimately help match levels of services to the diverse needs of entering youth.

Methods

Sample. Youth on average were 14.86 years of age (range = 5.67 to 20.14, $SD = 2.75$) and 71% male ($n = 128$). The sample included African American (79%), Caucasian American (18%), and other (3%) ethnic backgrounds. Youth resided in group homes located across the State of Maryland.

Procedure. A sample of 30 group homes was randomly selected from the approximately 140 DHR-licensed group homes in the State of Maryland. DHR sent letters to the selected group homes explaining the evaluation, level of expected participation, and timeframe of data collection (August through September, 2008). Data collection involved conducting chart reviews using the CANS to assess youth functional outcomes at two time points (i.e., admission into the group home and current or discharge, if appropriate). Only youth who resided at least three months in the group home and who had entered within the past year were included in the sample. In homes with more than 15 eligible youth, fifteen charts were randomly selected for review. From the selected group homes, 180 eligible charts were evaluated, out of the

estimated 1,250 youth currently residing in group homes. John Lyons, the developer of the CANS, provided consulting throughout the study.

The major research questions were examined via descriptive statistics, t -tests, and multiple regression analyses using the SPSS statistical software package.

Findings

Descriptives. Descriptive statistics on the demographic and study variables are summarized in Table 1. Table 2 summarizes correlations of study variables.

Table 1
Sample Size, Means, Standard Deviations, Skewness, and Kurtosis of Continuous Predictor and Criterion Variables

Variables	<i>N</i>	<i>M</i>	<i>SD</i>	<i>Skew</i>	<i>Kurtosis</i>
T1 Youth Age (years)	180	14.86	2.75	-1.02	0.90
Length of Stay at Group Home (months)	180	16.55	15.53	2.24	5.41
T1 CANS Life Domain Impairment	180	10.43	3.80	-0.26	-0.44
T1 CANS Child Strengths Impairment	179	19.85	3.86	-0.42	0.09
T1 CANS Child Behavioral/Emotional Needs	180	9.63	4.65	0.29	-0.002
T1 CANS Child Risk Behavior	180	5.86	3.66	0.37	-0.45
T2 CANS Life Domain Impairment	180	9.33	3.92	0.03	-0.53
T2 CANS Child Strengths Impairment	180	18.71	4.57	-0.46	0.54
T2 CANS Child Behavioral/Emotional Needs	179	9.37	4.35	0.10	-0.32
T2 CANS Child Risk Behavior	180	6.06	3.53	0.32	-0.48

Table 2
Correlations of Youth Age, Length of Stay, and CANS Scale Variables

Variable	1	2	3	4	5	6	7	8	9	10
1. T1 Youth Age (years)	1									
2. Length of Stay at Group Home (months)	-.36**	1								
3. T1 CANS Life Domain Impairment	-.17*	.10	1							
4. T1 CANS Child Strengths Impairment	.002	-.10	.42**	1						
5. T1 CANS Behavioral / Emotional Needs	.04	-.05	.50**	.34**	1					
6. T1 CANS Risk Behaviors	.01	.08	.63**	.42**	.64**	1				
7. T2 CANS Life Domain Impairment	-.10	-.04	.77**	.40**	.39**	.51**	1			
8. T2 CANS Child Strengths Impairment	-.04	-.19**	.32**	.80**	.28**	.32**	.49**	1		
9. T2 CANS Behavioral / Emotional Needs	-.04	-.06	.45**	.34**	.79**	.54**	.56**	.42**	1	
10. T2 CANS Child Risk Behavior	-.03	.06	.61**	.44**	.56**	.77**	.69**	.47**	.67**	1

Note: * $p < .05$. ** $p < .01$.

T-tests and Regression Analyses. In separate analyses for females and males, paired sample t tests were conducted to evaluate whether youth impairment as measured by the CANS differed from T1 to T2. For males, mean impairment in Life Domain Functioning and Child Strengths scores at T2 were lower compared to that at T1 (respectively, $t(127) = 6.35$, $p = .00$ and $t(126) = 6.31$, $p = .00$). No mean differences across time were detected on other CANS scales for male youth.

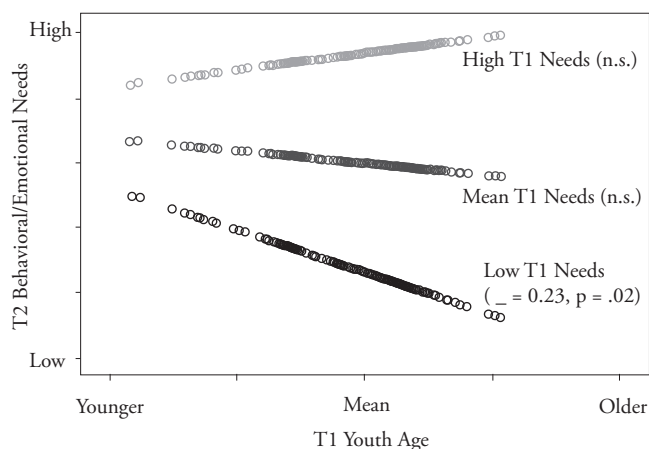
For females, mean Child Risk Behaviors at T2 were higher compared to that at T1 ($t(51) = -2.99$, $p = .00$). No mean differences across time were detected on other CANS scales for female youth.

In separate analyses for the two predominant ethnic groups in the sample (i.e., African Americans and Caucasian Americans), paired sample t tests were conducted to evaluate whether youth impairment as measured by the CANS differed from T1 to T2. No ethnic differences were detected.

Regression analyses revealed a main effect of gender, such that girls were rated as having more impairment than boys in T2 Life Domain Functioning ($\beta = -.16$, $p = .00$), Child Strengths ($\beta = -.17$, $p = .00$), and Child Risk Behaviors ($\beta = -.10$, $p = .03$), controlling for baseline scale scores, length of stay, and youth age. No gender differences were detected on T2 Child Behavioral/Emotional Needs scores. There were no main effects of age or length of stay.

A significant T1 Child Behavioral/Emotional Needs-by-age interaction was detected ($\beta = .10$, $p = .04$). At lower levels of T1 Child Behavioral/Emotional Needs, younger children were rated as having more impairment at T2 than older children ($\beta = -.23$, $p = .02$), while age was not a significant predictor of impairment at other levels of T1 Child Behavioral/Emotional Needs (see Figure 1). There were no other interaction effects.

Figure 1
T2 Behavioral/Emotional Needs on Youth Age at Three levels of T1 Behavioral/Emotional Needs



Conclusion

Findings of the present study suggest that group home placement might benefit some youth, but might exacerbate risks in others. In particular, the current sample of youth residing in group homes showed gender differences in outcomes. Males showed improvement in general life functioning (e.g., social, medical, school, and job) and strengths, but showed no difference across time in the areas of behavioral and emotional needs and risk behaviors.

Females, on the other hand, showed worsening in risk behaviors and showed no difference across time in the other assessed areas. Given the relatively small sample of females in this study ($n = 52$), replication of these findings would be important. Nonetheless, females and males on average did not differ significantly on age, length of stay, or functioning at intake, which might otherwise explain differences between these groups.

Furthermore, girls fared worse than boys overall in terms of later psychosocial outcomes, and younger children with lower initial levels of behavioral and emotional needs showed greater later impairment than their older counterparts. Together, these findings suggest that while group home placement may benefit some youth, the role of certain characteristics including gender, age, and initial level of need might differ in predicting outcomes. Implications for policy around group home placement and future research investigating the differential impact of group homes versus other community-based services (e.g., wraparound) will be presented.

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Poster 15

Perspectives on Residential and Community-Based Treatment for Youth and Families

Presenting: Richard Kamins, Bonni Hopkins & Pat Hunt

Introduction

For youth with severe behavioral health disorders, residential care is often the perceived treatment of choice. In the USA, approximately 50,000 children per year are admitted to residential treatment (RT). Further, one-fourth of the national funding on children's mental health is spent on RT. However, the research has demonstrated: RT does not meet the requirements of an evidence-based practice (Hair, 2005); therapeutic gains often do not maintain after discharge (Burns, Hoagwood & Mrazek, 1999); and, at a fraction of the cost, intensive in-home therapy is as effective if not more effective (Barth et al., 2007).

A White Paper was developed in response to concerns about the reliance on RT and the under-utilization of evidence-based alternative treatments. It investigated why some residential programs have positive outcomes and others don't, and what effective alternatives are available instead of RT.

Methodology

The investigators reviewed the literature on the efficacy of RT and alternative treatments for youth. We also conducted three community forums to obtain public input on the use of RT and other alternatives. Attendees at the forums included parents of children who had been in RT as well as young adults who had experienced those services. Additional participants included: policy makers; psychiatrists and psychologists; providers of crisis, residential and therapeutic foster care services; representatives from State Child Welfare, Education, Mental Health and Juvenile Justice agencies; juvenile courts; Governor-appointed commissions; advocacy centers; schools and various providers.

Findings

Findings fell into three major categories:

Lack of efficacy for many residential programs

Youth in RT often made gains between admission and discharge, but many did not maintain improvement post-discharge (Burns, et al., 1999). Similarly, any gains made during a stay in RT often did not transfer well back to the youth's natural environment, creating a cycle where youth were often repeatedly readmitted. Consistent with the research, parents in our focus groups stated that their children often returned to RT or entered the justice system after only a few months. Some of the reasons cited for this include lack of services in the community, lack of coordination with community supports and children don't have the skills they need to succeed in the community.

Key components in effective residential treatment

Although RT, in general, is not an evidence-based practice, some programs have shown positive results. The literature reveals that these programs have certain components in common.

- **Family Involvement.** The best programs partner with families and make sure there is meaningful family involvement during RT. Residential stays are shorter and outcomes are improved when families are involved.
- **Discharge Planning.** The more successful RT programs begin planning discharge at the time of admission. They determine what the youth needs for successful discharge and focus on eliminating barriers and building necessary supports. Gains are more likely to be maintained and readmissions decreased when attention is paid to what services and/or placement is needed post-discharge and the plan is executed.
- **Community involvement and services.** Effective programs facilitate community involvement and services while the youth are in RT. Teaching

youth the skills needed for reintegration into their community increases the chances of successful outcomes.

Effective alternatives to residential

When 24 hour care is necessary, the literature revealed that Therapeutic Foster Care (TFC) had better outcomes than RT. Youth in residential care did worse on developmental measures one year following placement, had higher re-admission rates after reunification, and had two to three times higher costs than TFC.

When youth may be treated safely at home, several approaches have been shown to be evidence-based practices. Integrated Community-Based Services such as Case Management and Wraparound approaches have demonstrated improved family functioning, decreased utilization of inpatient and residential services, and lower delinquency rates. Community based services such as Multisystemic Therapy, Functional Family Therapy also have shown impressive findings in effectively treating youth with disruptive behavioral problems, substance abuse, and/or delinquency and violence. These approaches are as effective or more effective than RT as well as more resource sensitive (Barth et al. 2007).

Conclusions

Although RT is a necessary element in the spectrum of care for youth with serious emotional disturbance—particularly for youth who cannot be treated safely in the community—community-based programs should be considered whenever possible. Over the last several decades, numerous evidence-based outpatient programs have been developed. In particular, Multisystemic Therapy (MST) and Functional Family Therapy (FFT) have shown strong positive outcomes in research and practice. In addition, case management and the wraparound approach to integrated community-based services are deemed evidence-based practices. When a child or adolescent does need 24 hour care, as an alternative to RT, Therapeutic Foster Care (TFC) should be considered.

The best RT programs focus on individualized treatment planning, intensive family involvement, discharge planning and reintegration back to the community. Because youth admitted to RT make most of their gains in the first six months and because of the adverse impacts of extended length of stays (e.g., loss of connection to natural supports, treatment gains frequently not sustained post-discharge, and modeling of deviant peer behavior), long-term residential stays are often not in the best interest of the individual, family, or society.

In summary, many effective alternatives exist to RT that are resource sensitive and have better clinical outcomes. When RT is required, programs that focus on family involvement, discharge planning and reintegration back into the community, and average three to six months in duration should be primarily considered.

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Poster 16

Predictors of Out-of-Home Placement by Race/Ethnicity

Presenting: Antonio Garcia & Maureen Marcenko

Introduction

The purpose of Children's Protective Services (CPS) is to protect the health and safety of children, which sometimes necessitates removal of children from their homes. Out-of-home placement is most often traumatic both for children and their parents and exposure to foster care can pose further risks to children. For these reasons, the decision to place a child in care is not made lightly. In fact, even when maltreatment is substantiated, placement only occurs in approximately 20% of cases (US DHHS, ACYF, 2000). However for children of color, the likelihood of placement is higher than it is for Caucasian children (Wulczyn, et al., 2005). Although scholars posit this disparity is largely attributable to reporting and assessment bias, arbitrary policies, and structural racism (Lau et al., 2003; Ruiz, 2002), relatively few studies have attempted to explore the contextually specific pathways that lead to CPS intervention among a racially and ethnically diverse nationwide sample of children. In an attempt to shed light on factors that lead to and prevent out of home placement, this presentation highlights findings from the National Survey of Child and Adolescent Well-being database (NSCAW), a longitudinal study that examines the experiences of children and families who received a CPS investigation. Utilizing data from Wave 1, the purpose of this study is to examine predictors of placement by race/ethnic group. Independent variables in the model include demographic characteristics, type of abuse, child mental health symptomatology, and parental/family stressors.

Method

The study sample consists of children six to fifteen years of age whose parents were the focus of a CPS investigation between October 1999 and December 2000 ($n = 2671$). The sample includes 797 African American, 1212 Caucasian, and 437 Hispanic children. Out-of-home placement occurred for over 25% ($n = 678$) of the sample.

The NSCAW study collected data from child interviews, teachers, social workers, foster parents, and caregivers, using a variety of instruments. In the current analysis data collected from child instruments, include: (1) Child Depression Inventory (CDI), a 27 item questionnaire, which asks children about their mood, interpersonal problems, ineffectiveness, anhedonia, and self-esteem (Kovacs, 1985), (2) Child Behavior Checklist (CBCL), which assesses their competencies and problem behaviors (Achenbach, 1991), and (3) The Trauma Severity Checklist, which was originally intended to measure symptoms associated with the long-term effects of sexual abuse. The TSC yields six subscales (dissociation, anxiety, depression, sexual abuse, sexual Problems, and sleep Disturbance) and a total score (Elliot & Briere, 1992). Social workers provided data on parental risk factors (e.g., child welfare history, substance abuse, poor parenting, cognitive/physical impairments, domestic violence, history of child abuse, monetary problems, low social support, and high stress) and type of maltreatment (i.e., physical abuse, sexual abuse, emotional abuse, or neglect) that lead to CPS involvement. Finally, current caregivers and foster parents provided ratings relative to the children's overall health.

Findings

Statistical analyses consist of bivariate analyses of independent and dependent variables by race. First, chi-square tests were employed to explore the relationship between placement status (i.e., the decision to place a child in out of home care) and the predictor variables. Racial/ethnic status was associated with whether or not children were placed in out of home care, $\chi^2(4, n = 2671) = 23.29, p < .001$. Over 30 percent of the African American ($n = 250$) sample, 23.3% of the Caucasians ($n = 283$), and 21.1% of the

Hispanics ($n = 92$) were placed in out of home care. Second, separate multivariate analyses will be conducted to identify significant predictors of out of home placement by racial/ethnic group.

Conclusions & Implications

It is anticipated the multivariate analyses will yield significant findings relative to predictors of placement outcome by racial/ethnic group. It will be particularly noteworthy to determine the potential influence that child mental health and parental risk or protective factors exert on these placement decisions. Prior research has examined the correlation between out-of-home placement and demographic and maternal problems (Zuravin & DePanfilis, 1997) however the NSCAW data provide an opportunity to explore the contribution of child mental on decisions to place. Furthermore, the availability of a diverse sample allows for the examination of placement predictors by race/ethnicity.

Racial disproportionality is an enduring characteristic of the American child welfare system (Courtney, et al., 1996; Hines, et al., 2004). Understanding the influence of a range of child and parental risk factors by racial/ethnic group can potentially inform the development of culturally sensitive policy and practice. The implications of the findings for child welfare and mental health policy and practice, particularly as it relates to the issue of disproportionality, will be discussed.

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Poster 17

School/Employment Status of Youth Accessing Residential Treatment or Intensive Family Services

Presenting: Karen Frensch

Introduction

Youth who drop-out or are pushed out of the school system face limited opportunities. "Each year in the U.S. an estimated 42,000 adolescents with psychiatric disorders cross the threshold into adulthood without completing secondary school... ill prepared for employment and citizenship." (Vander Stoep, Weiss, Kuo, Cheney, & Cohen, 2003, p. 123) Incapacity of the school system to educate students with emotional and behavioural disorders may set these students on the road to social failure including involvement with the criminal justice and adult mental health systems (Nelson, 2000).

This poster presents data on the academic functioning, school attendance, and employment status of youth at admission, discharge, and 12-18 months post discharge from either residential treatment (RT) or intensive family services (IFS). These findings are part of a four-year longitudinal study of the community adaptation of 210 youth involved with children's mental health programs in Ontario, Canada (www.wlu.ca/pcfproject). This study documents the long term functioning of youth across four life domains: school and work, family functioning, health and well being, and social connections and conduct.

Methodology

Participants were recruited from five organizations in Ontario, Canada providing mental health services to children aged 5 to 12 (3 agencies) and youth aged 12 to 16 (2 agencies). In-person interviews were conducted 12-18 months post-discharge with 107 RT parent/guardian informants and 105 IFS parent/guardian informants. Qualitative interviews were also conducted with 33 RT youth and 35 IFS youth. The average age of RT youth at follow up was 14.11, 78.5% were male and 54.2% were in the care of child protection services. The average age of IFS youth was 13.65, 71.4% were male, and 96.2% were living with their families. There were no differences between groups on age or gender, but fewer RT youth were living with their families ($\chi^2 = 65.04$, $df = 1$, $p < .001$).

Post-treatment data were obtained from parents/guardians and admission/discharge data from agency files. Clinical data analyzed included The Brief Child and Family Phone Interview, 3rd version (BCFPI-3)—School Participation and Achievement Subscale (Cunningham, Pettingill, & Boyle, 2002) and the Child and Adolescent Functional Assessment Scale (CAFAS)—School/Work Subscale (Hodges, 2000). The CAFAS School/Work Subscale assesses the severity of impairment in school or work related role performance. Estimates of school attendance, levels of academic difficulty, and employment status were provided by caregivers. Non-parametric tests were used to examine differences between groups and changes in functioning from admission to discharge and follow up.

Findings

Attendance

At admission 87.6% of RT youth and 95.2% of IFS youth were in school. At follow up, the proportion in school dropped to 75.9% for RT youth and 85.7% for IFS youth. Results for youth age 16 or older (when youth could legally leave school) showed that 54.1% of RT youth and 31.6% of IFS youth were not in school at follow up. A Wilcoxon signed-rank test revealed that there were significantly fewer RT youth age 16 or older in school at follow than at admission ($Z = -2.600$, $p < .05$, $r = -0.30$). There were also significantly fewer IFS youth age 16 or older in school at follow up than at admission ($Z = -2.309$, $p < .05$, $r = -0.27$).

Academic Functioning

At admission, 78.4% of RT youth and 60.4% of IFS youth experienced moderate to severe impairment in school/work roles as measured by the CAFAS School/Work Subscale. At discharge, 52.8% of RT youth and 66.3% of IFS youth had minimal to mild impairment in school/work roles. A Mann-Whitney test revealed that there was a significant difference between the distribution of scores for RT youth and IFS youth at both admission ($Z = -3.331$, $p = .001$, $r = -0.25$) and discharge ($Z = -2.300$, $p < .05$, $r = -0.19$). From admission to discharge, 55.8% of RT youth and 45.8% of IFS youth had a reduction in school/work impairment. A Wilcoxon signed-rank test revealed this change over time was significant for both groups ($Z = -4.511$, $p < .001$, $r = -0.39$ for RT youth; $Z = -4.535$, $p < .001$, $r = -0.35$ for IFS youth).

From the BCFPI-3, 53.4% of RT youth and 39.5% of IFS youth had grades that were suffering "a lot" at admission. The proportion of youth in both groups with grades suffering "a lot" at follow up increased to 59.4% for RT youth and 55.4% for IFS youth. This increase was not significant for either group over time. Obstacles to school success identified by youth at follow up included learning disabilities, mental health issues, peer conflict, substance abuse and family problems.

Employment

Few youth were involved in paid employment at admission (5.7% RT youth and 4.8% IFS youth). At follow up, there were significantly more IFS youth employed (20%) than RT youth (8.6%) employed ($\chi^2 = 5.60$, $df = 1$, $p < .05$). Seventy-five percent of RT youth not in school and 87% of IFS youth not in school were unemployed.

Conclusion

Gains made in school functioning at discharge were not maintained at follow up. Half of RT youth and one-third of IFS youth over 16 youth were not in school at follow up. More youth in school at follow up had difficulty than at admission. Most youth not in school at follow up were unemployed. These findings support providing academic supports to sustain successful school engagement over the longer term.

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Poster 18

The Lived Experience of Primary Caregivers of Children with Mental Health Needs

Presenting: Janis E. Gerkensmeyer, Ukamaka Oruche, Linda Stephan, Corinne Wheeler & Halima Al-Khattab

Introduction

About 10% of our nation's children have mental health problems serious enough to result in significant functional impairment (NIMH, 2002). Primary caregivers of these children face many challenges in getting their child's and their own needs addressed. They have to deal with consequences of their child's symptoms, such as aggressive, withdrawn, or self-destructive behaviors, not only within the family environment, but also within other settings such as schools, neighborhoods, and the legal system. The purpose of this study was to better understand the lived experience of primary caregivers of a child with mental health problems.

Methods

Five focus groups were conducted using a qualitative, descriptive design. Participants were self-referred from ads and word-of-mouth information about the focus groups in mental health clinics, parent support groups, and parent advocacy organizations. Groups met one time for about an hour and consisted of semi-structured interviews using open-ended research questions about their experiences. Follow-up probes were used when relevant information emerged. Sessions were tape-recorded with verbatim transcripts and field notes used to analyze responses. During the group session, inconsistencies and vague or cryptic comments were probed for increased understanding. After each group, investigators and moderators debriefed and wrote a group diagram and notes of themes, hunches, interpretations, and ideas. IRB approval and informed consent were obtained. Parents received \$40 for participating.

One primary caregiver participated per family. Twenty caregivers participated with one to seven in each group. Participants included biological mothers (70%), adoptive mothers (25%), and a grandmother (5%) who were primary caregivers for the past year of a child between 2 to 17 years old who had received mental health services at least once within the year before the focus group. Of these, 65% were married, 15% were divorced, 15% were single, and 5% separated; and 80% were Caucasian with 10% African American and 5% each Asian and Pacific Islander. Their average age was 46 years. The median household income was around \$50,000.

The average age and grade of their child with mental health needs was 12 years and 6th grade, respectively; and 50% were males. The majority were in special education (75%). On average, caregivers rated the seriousness of their child's problem as a 3.9 on a 5-point scale with 5 being very serious.

Findings

Following are examples of what participants shared about their lived experience. Verbatim quotes have been shared to capture the meaning reflected in some of the themes that emerged.

Access to care. In one caregiver's words, "you can find ample services as long as you don't have a job and commit 24 hours a day, 7 days a week for the next couple of years to find them." Caregivers shared that they were on waiting lists for Medicaid waivers for 7 to 8 years. Also, one stated, "services...are extremely fractured and extremely hard to access, and I am a forceful, pretty highly educated, middle class person with some resources and the ability to be an advocate and push against the system for my family members...It's this thick, impenetrable soup of inaccessibility and...you have to invest an incredible amount of time in educating yourself and finding out what your resources are." Another mother shared that she felt relief when her daughter, who was in a growing crisis, burned herself, cut herself, and wrote suicidal notes on *MySpace*, as that provided ammunition to help get her the crisis care she needed.

Living in fear. One mother shared, "I worry about her, the threat she poses to herself...with her bad judgment...it's the safety of other people around her... it's been my safety on occasion because she has...mad rages, physically hit me on three or four occasions." Another mother shared, "You shouldn't have to lock up the knives and the scissors and make them sleep with you...because you're afraid they're going to get up and stab someone to death in the night." Another mother shared, "I wish there wasn't such stigma about it...because we don't have to do this by ourselves and...to be ashamed."

I can't take care of me. One mother stated "It can be overwhelming if it falls to you," referring to "not all players taking equal responsibility." Another stated, "I'd like for my husband to be me." One mother described a parent with a child recently diagnosed with bi-polar disorder as in "the deer in the headlights phase... where other people don't believe you, and you cannot get help...you have to educate yourself fast... and you have to grieve...the change in your own expectations for your child...and for their life."

Include the whole family. Several parents from two of the groups indicated that siblings "need help coping as well" and that "there's an awful lot of resentment between" (them) because (those with problems) "have taken so much of Mom's time." A few suggested "include the whole family."

Good things do happen sometimes. One parent shared, "I have the prime set-up now...he's on SED Waiver with respite provided by a qualified foster parent...I pick up the phone and call her, and she's right there. She doesn't care if she gets paid. It's to help me because she sees what I struggle with. And it's just knowing that there's somebody out there that understands his behaviors, that's very good with him and can give me the help and support." Another parent reported that her 11 year old son who had been diagnosed with bipolar, ADHD, Tourette's, and OCD had spend the good portion of his years in state hospital or residential treatment and shared, "I am very pleased to report that today he has been out of the hospital for a year and a half. He has been in general education 90% of the time and gets straight As and Bs. I'm very proud."

Conclusions

The vast majority of these caregivers felt extremely challenged in getting their child's mental health needs addressed, having difficulty in accessing appropriate and competent care, experiencing stigma and blame, living in fear for their child's and other's safety, and having difficulty meeting their own needs—feeling overwhelmed and exhausted. Some parents were able to identify good things that happened related to their experience as a parent of a child with mental health needs, however, most of what was shared was related to the challenges they experienced.

Poster 19

Connecticut's Family-Based Recovery Program: Quality Assurance and Evaluation Results of a Statewide, Multi-Site Intervention for Children Affected by Parental Substance Abuse

Presenting: Jeffrey Vanderploeg, Christian Connell

Contributing: Karen Hanson, Jean Adnopo, Jo Hawke & Francis Gregory

Introduction

Parental substance abuse is recognized in the child protection statutes of most states and is known to be associated with higher likelihood of children being placed in out-of-home care¹ and with higher rates of serious emotional and behavioral disorders². In Connecticut, the Family Based Recovery (FBR) program provides home-based treatment to families affected by parental substance abuse. FBR is funded and administered by the Department of Children and Families (DCF), and currently is implemented in six sites across the state.

Programs within a system of care often are challenged to design, fund, and sustain a data collection and reporting mechanism that promotes a culture of data-informed decision-making. Consistent with best practices for community-based programs³, our quality assurance and evaluation plan was designed to track the implementation of FBR at each site and across the network, allowing stakeholders to monitor important indicators of program implementation, develop timely corrections, and maintain high quality of care. Our approach and findings will have direct relevance to conference participants who wish to design and implement similar efforts for programs within their system of care.

In this poster presentation, we will share quality assurance and evaluation data from the first year of FBR implementation. Findings are grouped into five domains: (1) socio-demographic and case characteristics; (2) child and caregiver risk factors; (3) caregiver clinical functioning; (4) programmatic adherence; and (5) discharge outcomes. The poster fits in with a 2009 conference track of "Integrating Evaluation and Performance Measurement."

Methodology

The FBR network. The FBR network is composed of a multidisciplinary team of stakeholders. Six FBR teams located in community-based clinics across the state began seeing clients in January 2007. Connecticut DCF oversees all operations of the FBR network. Staff members at The Yale Child Study Center (YCSC) act as program coordinators for the FBR network, and investigators at Yale School of Medicine and the University of Connecticut designed and implemented the quality assurance and evaluation plan.

Data entry and management. FBR clinicians are responsible for collecting and entering all data into a web-based system that is maintained by YCSC. At the end of each quarter, YCSC coordinators extract data from

With the degree of challenge they shared, it is evident that there are many unmet needs to be addressed to improve the well-being of the child, caregiver, and family.

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National Institute of Mental Health. (2002). *Blueprint for change: Research on child and adolescent mental health*, Washington, DC: Department of Health and Human Services.

the web-based system and send these data to evaluators. Each quarter an aggregated report is generated and distributed to all sites and stakeholders. Each site also receives a report summarizing their results individually.

Findings

Socio-demographic characteristics. To date, 135 cases (291 clients) have been served by FBR through its first year of implementation. Approximately 80 percent of referrals to FBR come from regional DCF offices and 80 percent of cases involve a mother-child dyad. On average, mothers are 27.4 years old ($SD = 5.9$ years) and children are 7.4 months old ($SD = 12.2$ months). Over half (55%) of mothers are Caucasian, more than one-quarter (28%) are African-American, and 13% identify as Hispanic/Latina. Families receive a combination of cash (e.g., employment, TANF) and non-cash financial supports (e.g., Medicaid, food stamps, housing subsidy). Our network-wide and site-specific quarterly reporting allows stakeholders to monitor trends in the characteristics of the FBR population over time.

Risk factors. Caregivers served by FBR have a substantial risk profile, including psychiatric illness (41%), criminal conviction (41%), and sexual abuse victimization (25%). During pregnancy, mothers most frequently reported the use of tobacco (53%), marijuana (51%), alcohol (22%), and cocaine (20%). Tracking these and other risk indicators will inform the broader evaluation of FBR by allowing examination of the contribution of caregiver and child risk to important outcomes related to the safety, permanency, and well-being of children affected by parental substance abuse.

Clinical functioning. At baseline, nearly one-third (29%) of caregivers had elevated scores on the Edinburgh Depression Scale. The Parenting Stress-Index Short Form revealed that 17 percent of mothers had elevated scores on the Parental Distress subscale. The Parental Bonding Questionnaire yielded few clinically elevated scores; however, this measure captures an affective element of parenting that is likely to be associated with program completion as well as positive outcomes for children. Understanding baseline clinical functioning is critical to guiding treatment planning and service delivery.

Programmatic adherence. We will present data on adherence to the FBR model. This includes such factors as entering cases into the web-based system (94% compliance), identifying a main problem (85% compliance), and completing intake assessments, functional assessments, feedback reports, genograms, and treatment plans. Each of these indicators allows stakeholders to track compliance with the FBR model, and ensures that necessary interventions at specific sites can be planned to ensure model fidelity and quality of care.

Discharge outcomes. Preliminary findings suggest that 75% of children remain with their parent(s) at the time of discharge. To date, 84 cases have been discharged from FBR but not all cases have completed clinical measures. All clinical discharge information available will be presented.

Conclusion

FBR is intended to provide treatment to children who are at-risk for later emotional and behavioral disorders as a result of exposure to parental substance use. Programs like FBR are critical elements of a comprehensive system of care for children and families. This poster presentation showcases not only findings from our quality assurance and evaluation, but an approach to reporting quality assurance and evaluation data that allows stakeholders to monitor fidelity and quality of service delivery over time.

Poster 20

Factors Effecting Family Participation in Mental Health Services for Children with SED

Presenting: Lindsay Satterwhite

Introduction

The implementation of systems of care for children with severe emotional disturbances and their families has been widely adopted; the concept of getting service providers to collaborate with each other and with the family to develop a relevant and comprehensive treatment is appealing. However, evaluations of system of care programs found less than desirable results (Cook & Kilmer, 2004; Kutash & Rivera, 1995). One primary criticism of the implementation of systems of care is that it fails to emphasize the inclusion of involvement of family members, specifically primary caregivers (Brannan, Heflinger, & Foster, 2003; Measelle, Weinstein, & Martinez, 1998). Family involvement has been a difficult piece in the implementation of systems of care, and it is particularly important. Brannan (2003) asserts that attention to family influences is crucial to improving the effectiveness of treatments in community and service system settings.

Specifically, the primary caregivers of children with severe emotional disturbances have been shown to profoundly effect treatment and outcomes. Caregiver strain significantly impacts children's use of mental health services (Brannan & Heflinger, 2007). In fact, family factors in general and caregiver characteristics specifically have consistently been shown to have effects on help-seeking (Bussing, et al., 2003), continued use of services (McKay, et al., 2001), receiving more restrictive services (Bickman, Foster & Lambert, 1996; Brannan & Heflinger, 2007; Foster, Saunders, & Summerfelt, 1996), having longer lengths of stay (Foster, 1998), and incurring higher costs of care (Brannan, Heflinger, & Foster, 2003).

However, family factors are not the only influences present that effect service use and outcomes. Aday and Andersen (1974, 1981; Andersen & Davison, 1996) developed a conceptual model for the factors that influence medical service use and outcomes, including: predisposing, enabling, need, community, and service system factors. According to this model, individual (child), family, and service factors are identified as having enabling and predisposing characteristics, and outcome and treatment effects are observed.

Study Purpose

In order to contribute to the body of work in this area, the present study seeks to examine the role of child, family, and service system characteristics on family participation in treatment. The importance of family participation in treatment, and the difficulty that systems of care have had with getting families involved in treatment in meaningful ways have already been established. Therefore, this model will examine characteristics of the individual child, the family system,

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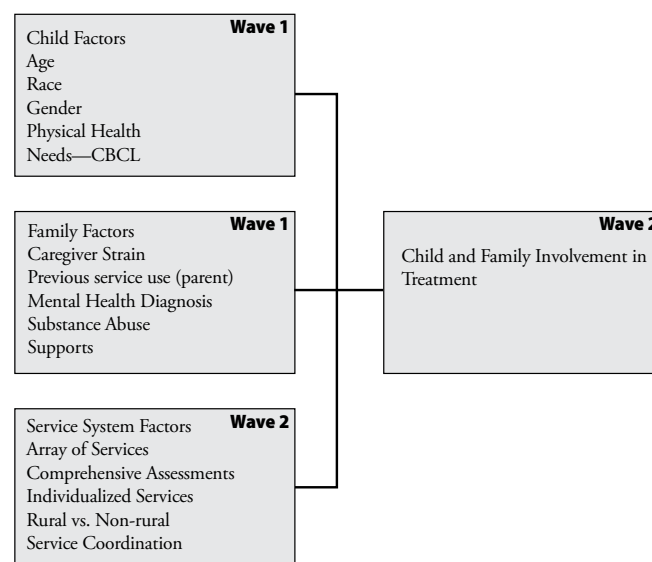
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and the service system that effect the level of family participation in treatment, so that systems of care programs may attempt to more effectively foster family involvement.

Methods

This study is a secondary analysis of existing interview data from the Impact Study of Managed Medicaid in Tennessee. As part of a larger study (Cook, Heflinger, Hoven et al., 2004), caregivers of children enrolled in Medicaid who had a serious emotional disorder (SED) had been interviewed in a baseline interview. The second wave of data collection, six months later, included a service testing model described below. This study combines baseline and wave 2 data to test the conceptual model examining child, family, and service system factors that influenced family participation in their child's treatment planning during the six months between baseline and wave 2.

Figure 1
Conceptual Model



Sample

Participants include 92 children who met the criteria for SED at baseline, based on a history of intensive levels of mental health service or great quantities of community-based mental health service in the past, and their families. The participants were enrolled in and had received mental health services over the past several years through the state's Medicaid program.

Measures

Instruments used for data collection of the children's level of need include the Child Behavior Checklist (CBCL; Achenbach, 1991) and the Child and Adolescent Functioning Assessment Scale (CAFAS; Hodges, 1994). Physical health status was measured using a single item from the National Health Interview, and child age, race, and gender was also available. At the family level, the study used the Caregiver Strain Questionnaire (Brannan, Heflinger, & Bickman, 1997). In addition, caregivers were asked to describe their own previous use of mental health services and any diagnoses, and their own history of drug/alcohol abuse. Caregivers also rated their family or own well-being and the level of supports they were receiving on a scale.

Between baseline and wave 2, service systems were assessed in the following areas: service access and array, comprehensive assessment, individualized services, and service coordination. Additionally, the dichotomous variable of rural versus non-rural environment was examined.

The dependent variable is Family Participation in Treatment Planning. This and the other service system scales are 6-point scales (ranging from Completely Unacceptable [Planning and evaluation conducted at times/places that prevent family/child participation] to Optimal [Key family member/child are full, effective ongoing participants in all aspects of service planning and delivery]) that are completed through a trained interview as part of a standardized service testing process that included interviewing the caregiver, the mental health service provider, the child's teacher, and other personnel who had been involved over the past six months. Service testing methodologies have been successfully used to assess the level to which system of care principles, implemented at the organizational level, are being expressed at the level of services to families (Hernandez, et al., 2001; Stephens, Holden, & Hernandez, 2004).

Analyses

In addition to descriptive analyses of all factors and bivariate analyses to examine differences between children with high levels of family participation versus those with low levels, we use a multivariate regression, stepping in each level of factors: first child factors, then family factors, and then service system factors.

Findings & Conclusions

Eighty percent of the children were rated as having adequate (4 or higher on a 6-point scale) family participation in treatment. Examples of high and low levels of family participation will be described. Specific characteristics of the child and the family were demonstrated to influence involvement in treatment in the bivariate models. Multivariate models are currently under development and will be finalized in time for this proposed poster presentation. It is expected that certain service system characteristics also encourage or discourage family involvement. Hopefully, the results of this study can inform service providers about increasing family involvement and decreasing elements of their service provision that discourage family involvement. Additionally, service providers can be aware of identified child and family characteristics that correlate with low family involvement create more opportunities to encourage family involvement. Implications of strong influences will be examined more profoundly, and implications will be discussed.

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Poster 21

Framework for Empowering Parents as Change Agents: From Science to Action

Presenting: Kimberly Hoagwood, James Rodriguez, Geraldine Burton & Marlene Penn

Introduction

Despite dramatic advances over the last decade in identifying effective interventions to both prevent and treat childhood mental health problems, significant gaps persist in families actually accessing and using mental health services. The gaps between mental health care need and actual service delivery are especially pronounced among minorities, and more so for mental health care than other forms of medical care (USPHS, 2001). A range of substantive obstacles has been shown to interfere with families' access to and use of services, such as lack of knowledge about services, distrust of providers, and lack of self-efficacy in navigating the complex service system (McKay et al., in press; McKay, McCadam, Gonzales, 1996; Owens et al., 2002).

To address problems in access, several family-based service models have been developed with the common goal of supporting family's engagement with or knowledge about mental health services (e.g., Bickman, Heflinger, Northrup, Sonnichsen, & Schilling, 1998). Other types of support interventions have been developed to address specific types of mental health issues. These include psychoeducation and support for families of youth with bipolar disorder (Fristad, Goldberg-Arnold, & Gavazzi, 2002); interventions addressing parent stress, stigma, social isolation, and other barriers to service use among families of children disruptive behavior disorders (Ireys, DeVet, & Sakwa, 2002; Kazdin, Holland, & Crowley, 1997; Kazdin & Wassell, 2000; McKay et al., in press; Ruffolo, Kuhn, & Evans, 2006); strategies to address problems of clinician engagement and retention of families in services (McKay & Bannon, 2004); parent support interventions to promote flexible service planning using wraparound services (Bruns & Hoagwood, 2008) and to encourage parent connections with services (Kutash, English, Duchnowski, Lynn, Romney, & Greeson, 2006).

Within the child mental health field, the impact of family education and empowerment interventions are not well studied (Farmer, Dorsey, & Mustillo, 2004). However, parent involvement has been documented to influence the likelihood of treatment completion, improved parent-child relationships, increased confidence in parenting skills, decreased parental stress, and improved academic outcomes (e.g., Kazdin & Wassell, 2000; Ruffolo et al., 2006).

Background to the Parent Empowerment Program (PEP)

This poster presents a New York based Parent Empowerment Program (PEP), that was originally developed by a group of dedicated parent advocates working with the Mental Health Association of New York City (NYC), along with researchers from Columbia University and Mount Sinai, and policy-makers from NYC and NYSOMH. It was developed in response to a need to better prepare parent advisors in NYC to more effectively address the needs of families whose children have mental health problems. This training program for parent advisors, who provide peer-to-peer support, has been examined in three studies in New York, including NYC community-based settings, NYC schools and statewide communities, as well as a study in Utah. In addition, the PEP program has been adapted for work with children and families in the child welfare system, and is being studied across multiple child welfare systems in the states of Texas, New York, and Washington.

PEP and its adaptations are modeled in part on the Fort Bragg service empowerment intervention, the only empirically based model of parent empowerment for children in the mental health arena (Bickman et al., 1998). As a first step to its adaptation in NYC to make it appropriate for use with low-income, urban populations, a group of family advisors, state

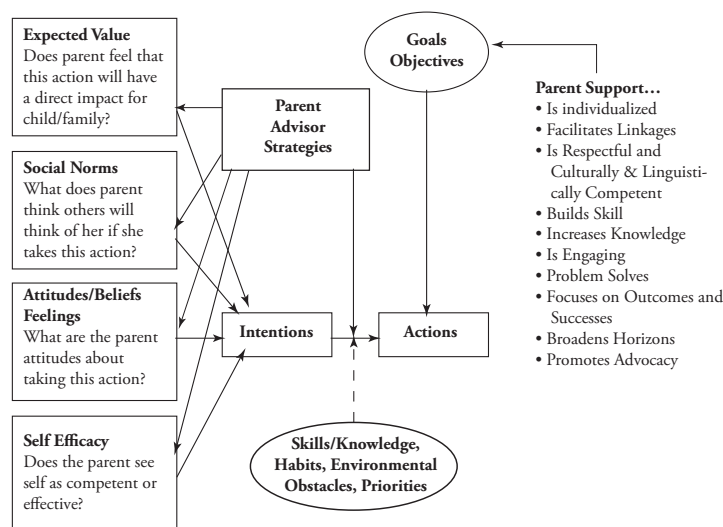
policy-makers, and researchers met for over four years to adapt, refine, and pilot this model. Through these pilot studies, the PEP model evolved to focus specifically on (a) the concept of empowerment as a process, (b) the challenges associated with parental stress, and (c) the application of an explicit conceptual framework and a unified theory of behavior change (Jaccard et al., 2002) to tailor the empowerment process for the needs of individual parents.

Empowerment: Developing Parent Competencies as Agents of Change

The process of parent empowerment has been conceptualized as a "process of recognizing, promoting and enhancing [parents'] abilities to meet their own needs, solve their own problems, and mobilize the necessary resources in order to feel in control of their own lives" (Gibson, 1995). Consistent with this concept of empowerment, the PEP training focuses parent advisors on meeting parents where they are at in this process, and learning to identify strategic points of interventions in order to help parents effect change, in their sense of self-efficacy, affect, and beliefs about their possible roles as an effective agent of change for their child. The goal of PEP is to work with parents to address barriers to their capacity as change agents, provide the necessary knowledge to alter attitudes and beliefs, and foster specific skills and competencies for navigating and interacting with various providers, systems and legislation, thereby ensuring that their child's care is consistent with their beliefs, values, and goals. Through this process, the PEP model adheres to a set of principles for parent support that were developed collaboratively by parent advocates and researchers working with Kansas Keys Inc. (see Figure 1). These principles serve to ground the work of parent advisors as they work with families to develop family goals, even as they are challenged to operate under the various constraints of their job context.

Figure 1 also demonstrates how the Unified Theory of Behavior Change (Jaccard et al., 1999; Jaccard et al., 2002; NIMH Workshop Report, 1991) is applied in the PEP model to help parent advisors better understand factors that motivate parents' intentions (e.g., social norms, attitudes and beliefs, expectancies, self-efficacy) and behaviors (e.g., prior habits, environmental constraints such as available resources or services, knowledge, skills, etc.). Through the development of trusting collaborative relationships paired with educational content, parent advocates systematically assess factors that may influence parents' willingness and abilities to act on goals, utilizing specific strategies (e.g., provide information, share knowledge, teach skills, etc.) to promote parents as change agents. This model provides a conceptual framework for testing the effectiveness of family support services in children's mental health, a much-needed area for future research.

Figure 1
PEP Model: Parents As Agents of Change



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Poster 22

Simulating Waiting List Reduction Strategies in Children's Mental Health: A Discrete Choice Conjoint Analysis of Parental Preferences

Presenting: Charles Cunningham

Introduction

Most children with mental health problems do not receive professional assistance. Those accessing service often wait for extended periods of time. This study is part of a program of research adopting methods from marketing research to involve parents in the development of services that might be useful while they waited for children's mental health treatment. This study's conjoint analytic methods were developed by mathematical psychologists Tukey & Luce and are widely used by marketing researchers, health economists, and transportation economists (Hensher, Rose, & Greene, 2005). These methods have only recently been extended to the design of children's mental health services (Cunningham et al., In press).

Methodology

Participants. At referral to regional intake departments, we contacted parents seeking services for 4 to 12 year olds with mental health problems.

Survey Development. In this project's survey development phase, we conducted eight focus groups exploring services that might be helpful to parents waiting for treatment. Discussions were transcribed and analyzed thematically.

Procedure. Using focus group themes, we derived 13 4-level waiting list service attributes. We composed a partial profile, discrete choice conjoint survey. Each participant completed 25 choice tasks presenting experimentally varied combinations of the study's attribute levels. Each choice task presented three interim service options, each defined by two attribute levels. We sent a survey link to parents with internet access and conducted home visits to those without internet access. 81 % of the surveys were completed.

Data Analysis. Using a preliminary sample ($n = 69$) of the participants who will complete the survey prior to this presentation, we computed individual parameter estimates with hierarchical Bayes. Next, we used multinomial logit to generate utility values reflecting the influence of each waiting list service attribute level on participant choices. We computed importance scores reflecting the relative sensitivity of participants to variations in the levels of each attribute. We used latent class analysis to identify segments with different waiting list service preferences, and MANOVAs, ANOVAs, or nonparametric statistics to compare the importance scores, utility values, and demographics of each segment. Finally, we used randomized first choice simulations to model each segment's response to different interim service options.

Findings

Latent class analysis yielded two segments with 60% of parents in an Action Focused segment and 40% in Time Sensitive segment.

The *Action Focused* segment showed a significantly stronger preference that, prior to being placed on a waiting list, all parents receive explanations about the way agencies provided service. Action Focused parents were more sensitive to service processes in which therapists and parents agreed on an interim service plan. They preferred more frequent checks on their child's progress and more frequent updates on their child's position on the waiting list. They were willing to devote twice as much time each week (2 hours) to an interim service plan. They preferred programs that helped them understand childhood mental health problems, develop skills to assist their child, and acquire information

about the assessment and treatment process they were waiting for. They were willing to use either phone or face-to-face contact with therapists and responded positively to the opportunity to work with parent groups. Finally, they preferred materials providing step-by-step solutions to their own difficulties.

Time Sensitive parents would devote less time (1 hour each week) to an interim service plan. While both segments preferred weekday evening services, this attribute exerted a greater influence on the Time Sensitive segment's choices. Time Sensitive parents demonstrated a stronger preference for less frequent progress checks and waiting list updates. Like Action Focused parents, they preferred interim services that helped them understand child mental health problems and develop skills to help their child. This segment preferred working alone rather than in groups. In contrast to the Action Focused segment, they were interested in information about difficulties parents experience but not ready to pursue step-by-step solutions.

Both segments preferred involving their child in 66% of the interim service activities, and favored programs supported by both parental experience and scientific evidence.

Simulations predict that, while waiting for services, Action Focused parents would use either a skill building parenting group (50.6%) or a self-paced parenting program (49.4%). Time Sensitive Parents (78.2%), in contrast, would favor a briefer self-paced program that could be pursued at home. Overall, simulations predict 38.6% of parents would choose a parenting group while 60.9% would select a self-paced option.

Conclusion

The development of interim service options needs to be informed by the differing preferences of the Action Focused and Time Sensitive segments. Skill building parenting groups and self-paced programs constitute cost-effective options to simply waiting for children's mental health services (Montgomery, Bjornstad, & Dennis, 2008); simulations suggest virtually all parents waiting for services would utilize one of these programs.

Action Focused parents were particularly sensitive to the need for explanations regarding how children's mental health agencies work. Focus groups suggested that concern regarding the fairness of waiting list decision processes was a considerable source of stress to parents. Organizational justice research suggests that a failure to understand how decisions are made, concerns that processes are unfair, or concerns that decision outcomes are not equitable adversely affect health and emotional well being (Colquitt, Greenberg, & Zapata-Phelan, 2005).

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Poster 23

The Iterative Process of Implementing and Evaluating a School Based Depression Prevention Program

Presenting: Charles Cunningham

Introduction

The World Health Organization (1994) states that “schools have a central position in many children’s lives...and may be the most sensible point of intervention for mental health services.” Schools are, in fact, an integral component of a system of care for children’s mental health. Universally delivered programs hold particular promise in school settings because they tend to be non-stigmatizing and provide for the mental health of all children (Offord, Kraemer, Kazdin, Jensen & Harrington, 1998).

Promising effects of cognitive-behavioral therapy (CBT) interventions to prevent depression have been reported in the literature (e.g., Clarke et al., 1995). A key issue in school based mental health research is determining how best to transport empirically supported programs to the classroom setting (Hoagwood & Olin, 2002).

For ten years, a team of mental health professionals at the Hamilton-Wentworth District School Board (HWDSB) has been working, in active partnership with Weisz and colleagues (Judge Baker Children’s Center, Harvard University) in the area of childhood depression to select, adapt, pilot, revise, implement, and test a depression prevention program for middle school students. This poster presents the knowledge gained in this iterative process.

Methodology

The HWDSB has selected a proven, manualized CBT intervention as its universal prevention program (Weisz et al., 1997; Weisz, Southam-Gerow, Gordis & Connor-Smith, 2003). The Act and Adapt program teaches students to manage academic and social stress and to prevent the onset of mood problems. This intervention yields positive outcomes for depressed children (Weisz et al., 1997) and students who are at risk for depression ($ES = 0.40$, Weisz, personal communication). With close consultation and support from Dr. Weisz, the Act and Adapt program has been translated into an approach called Choosing Healthy Actions and Thoughts (CHAT) that can be delivered universally in grade seven classrooms.

Prior to the first pilot test, three years of development (e.g., review of program and video scripts for Canadian schools, integration with specific Ontario curriculum expectations) and system preparation (e.g., consultation with teachers and school administrators) were completed. The CHAT program was piloted in 18 HWDSB classrooms. Both established and internal measurement tools were utilized during pilot phases, and the latter, more school-relevant tools were tested for psychometric strength. CHAT was extended to higher-needs inner city schools in year three, to explore its utility with students at risk of emotional and behavioral problems.

Open trials of the CHAT program yielded significant positive outcomes on measures of cognitive and behavioral coping ($ES = 0.3$), and smaller effects for measures of depressed mood. Students in higher-needs inner city schools made gains equivalent to their peers who attend schools that are subject to less environmental stress (Short, 2005). Parents and students also rated the program favorably (Short & Cunningham, 2003).

With support from the Provincial Centre of Excellence in Child and Youth Mental Health at the Children’s Hospital of Eastern Ontario (CHEO), the HWDSB joined with McMaster University to conduct a randomized trial of the CHAT program, beginning in 2006. This evaluation involved two cohorts of grade seven students ($N = 664$) who

received the intervention and were followed up at 6 and 12 months, and an equivalent control group ($N = 530$) that participated in the same measurement points. A total of 35 treatment and 35 matched control classrooms participated in the trial.

In addition to pre-, post- and follow-up measurement, the trial included fidelity checks and benchmark surveys to alert the team to protocol violations and possible implementation barriers. A discrete conjoint experiment was also conducted in order to test teacher preferences for the “packaging” of future versions of CHAT.

Findings

The following enablers facilitated the implementation of this evidence based intervention within the school district setting:

- Support and encouragement from Weisz’s laboratory at Harvard University.
- Solid evidence based intervention, with engaging features for students and teachers (e.g., teacher manual, DVD).
- A dedicated, multidisciplinary, HWDSB team.
- Support from senior management within the school district.
- Seed funding from the school district during pilot phases of the project.
- Attention to the need for close communication with schools.
- Alignment to the Ontario curriculum so as to ensure teacher comfort with the program material.
- A co-facilitation model that included mental health and teaching professionals.
- Patience and perseverance on the part of the steering team, university partners, and school teams.
- Funding for the randomized trial from the Provincial Centre of Excellence for Child and Youth Mental Health allowed for a rigorous evaluation of this program, along with further collaborative opportunities with local university partners.

Mandated to foster research use and the uptake of evidence-based practices within the school district, the HWDSB Evidence-Based Education and Services Team (E-BEST) provided a platform for this iterative process.

The following barriers arose during the implementation and evaluation of CHAT and may be anticipated in future efforts to embed evidence based practices within school districts:

- Work related to the development, implementation, and evaluation of an empirically-supported program was not a typical part of school district life; a lack of dedicated time.
- There was no road map for implementation of evidence based practice in schools when the CHAT team began this project in 1999.
- The mobilization and development/readiness work took several years to achieve.
- A lack of sufficient funding at the onset of the project resulted in a slower than expected rate of progress, and sustaining motivation became an important goal of the endeavor.
- The CHAT team needed to devote time to educate school officials about depression and mental health, and links to student engagement and achievement.

Conclusion

The iterative process of implementation and evaluation of CHAT has led to many discoveries that are relevant to the transport of evidence based protocols into school district settings. When classrooms serve as laboratories, and school based mental health professionals take on an evidence brokering role, it is possible to bring science to practice in a meaningful way for teachers and students. This work contributes to a broader system of children's mental health care in that this universal program complements community based services for children struggling with depressive symptomatology within our region.

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Poster 24

Families First: Innovative Approaches to Increasing Family Involvement in Treatment

Presenting: Amy Winans, Malisa Pearson & Kay Hodges

Introduction

This poster presents three novel approaches to engaging parents across a variety of settings within the system of care with the assistance of empirical measures. While each approach and setting is distinct, all share a common goal of empowering families and building a stronger partnership between caregivers and clinicians.

The first setting is the Association for Children's Mental Health (ACMH), which is a family organization with statewide staff and membership who support activities to enhance the system of services that address the needs of children with serious emotional disorders and their families. The ACMH trains parent advocates to conduct peer-to-peer family support and education. The second setting is a child welfare agency, KVC Behavioral HealthCare, Inc., which provides parents with individualized, home-based parent management training. The third setting is the Level of Functioning (LOF) Project, which is sponsored by public mental health in Michigan. The LOF Project offers a training program for practitioners on how to share assessment results with parents or caregivers who can then actively participate in tracking their children's progress.

Methods

Description of Measures

Caregiver Wish List. The Caregiver Wish List (CWL; Hodges, 2002) has two parts. The first part, entitled Skill Wish List for Your Child, consists of 14 questions about the child's behavior. The second part, the Skill Wish List for You, consists of 53 items that ask the caregiver about his or her own parenting behavior. The items are grouped into six categories by skill domains: (a) providing direction and following up, (b) encouraging good behavior, (c) discouraging undesirable behavior, (d) monitoring activities, (e) connecting positively with the youth, and

(f) problem solving orientation. Each item consists of a question and a 5-point response option. The CWL is designed to fully inform the caregiver about how his or her answers to the questions "map" onto the parenting skills assessed by the measure. The parent's answers transfer onto a sheet that specifies the skill assessed by each question. In this way, the parent can see exactly which skills are considered areas of strength versus areas in need of improvement. In addition, after answering all of the items on the CWL, the caregivers are asked to identify their three "top wishes or goals." This provides the caregivers an opportunity to determine the skills they are most interested in improving or acquiring.

Program Descriptions

Setting 1: Association for Children's Mental Health

Currently, the purpose of this program is to train parent advocates on how to administer, interpret, and share the results of the CWL with parents. The goal is that parents would then gain a better understanding of their needs and those of their children. Thus, when entering a therapeutic setting the parents would already have some knowledge and common language with which to approach the therapist. Ultimately, this new knowledge may lead to greater feelings of empowerment for the caregivers when negotiating the treatment system and also may foster stronger partnerships between the caregivers and clinicians. Presently, five parent advocates have completed training and are beginning to use the measure in the field. Training of 25 to 30 more family advocates will commence in early December, 2008.

Because each full-time advocate works with an average of 15 families at any given time, the potential impact that this program can have is tremendous. Part of the training process includes a discussion about how to collect the data gained from the CWL and to identify possible research opportunities.

Setting 2: KVC Behavioral HealthCare

The purpose of this program is to train and support front-line child welfare staff to identify goals and provide home-based family interventions that develop strengths based and family-driven child management and family interaction skills. The CWL is used as a vehicle to see challenges through the parent's eyes, to facilitate development of a collaborative working relationship between staff and parents, and to encourage family-driven goals while also conducting regular assessments of developing skills and abilities between parents and children.

Setting 3: Level of Functioning Project, Michigan

This project created a process of sharing outcome data that were used to facilitate greater communication and collaboration between treatment providers and parents. Two surveys were developed; one targeted clinicians and assessed whether and how they share results, and the second was geared toward caregivers. Forty clinicians and 25 caregivers from across the state completed surveys. Treatment providers were provided an email survey. After analyzing their responses, a script was developed to explain CAFAS information to caregivers; this standardized script was presented to each of four parent support groups. Parents were given a questionnaire and then participated in a focus group.

Results

Setting 1: Association for Children's Mental Health

This program is in the earliest stages of development and training of the implementation model, and preliminary results will be presented at the time of the conference. Qualitative data including feedback from the advocates who go through the training will be presented.

Setting 2: KVC Behavioral HealthCare

At this time data have been collected on 65 families and pre-and post data will be analyzed and presented.

Setting 3: Level of Functioning Project

Less than half (45%) of treatment providers report that they typically share CAFAS results with families. In focus groups with caregivers ($N = 21$), 52% of parents stated that the therapist shared the results with them in numbers or graphs. However, many parents stated that this happened only after they requested the results.

Discussion—Next Steps and Future Goals

Various strategies for increasing family involvement in treatment at mental health and child welfare settings will be presented, including parent advocates who serve as assessors during the family's first contact with agencies and intermittently check with families as they progress through the system. Parent advocates use empirical outcome measures that allow parents to assess themselves (rather than being judged) and to determine whether this approach increases their engagement or enhances outcome results. These strategies help teams of clinicians and parent advocates train clinicians about how to better involve families in guiding and tracking their child's progress through the child welfare and mental health systems.

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Poster 25

Supporting Positive Transitions to Kindergarten: Parent Perspectives on Early Childhood Education Systems

Presenting: Anna Malsch

Contributing: Brianne Hood

Introduction

Entering kindergarten is a major milestone in the lives of children and families. The experience of starting school involves significant change that may be particularly challenging when children have disabilities (Rosenkoetter, Hains, & Fowler, 1994). Although a child's first day of kindergarten is a one-time event, transition to school "is a process in which child, family, school and community interrelate over time" (Pianta & Cox, 1999, p. 4). When transition is successful, children are engaged and feel positive about school, parents are partners in their children's learning, and schools provide experiences that promote the success of individual children (Ramey & Ramey, 1999; Wright, Diener, & Kay, 2000). However, transition problems can have serious consequences. Research indicates that the early years of elementary school are critical (Raver & Knitzer, 2002), especially for children with challenging behaviors (Fox, Dunlap & Cushing, 2002). Early problems are associated with academic difficulties that persist in later school years (Wright, et al., 2000). In this paper we describe the Transforming Transitions to Kindergarten: A Family-Provider Team Approach (T2K) project. T2K aims to promote effective integration of children with emotional/behavioral challenges into community based early childhood settings and ensure the successful transition of these children into kindergarten. The intervention was designed to strengthen transition practices by improving communication between Head Start programs,

schools, and parents, increasing parent involvement in transition, and doing individualized, family-centered transition planning with children with challenging behaviors.

Methodology

The intervention sought to integrate current Head Start policies and practices with promising transition practices identified in the literature. The team-based family-driven transition model included the following activities: (1) Meetings between a Transition Liaison and the parents of each child to discuss transition to kindergarten, (2) Parent identification of members for their child's "transition team" (e.g., Head Start teacher, receiving kindergarten teacher, mental health professional, school counselor, special education coordinator, etc.), (3) transition meetings to develop an individualized transition plan for each child, (4) development of a transition portfolio for each child, (5) a focus on communication between parents and teachers and (6) strategic planning to ensure the child's positive initiation to the new school and classroom.

Head Start parents, kindergarten teachers, and Head Start teachers were interviewed in the spring while children were in Head Start and in the fall after the children transitioned to kindergarten. The interviews were conducted using scripted questions and probes, and were audiotaped; transcripts were prepared for each of the interviews. Transcripts were coded and analyzed using NUD*IST software. Three investigators worked independently with the transcripts to generate

preliminary codes using both latent and manifest content analysis techniques. First level codes were compared in joint meetings. Second-level coding focused on establishing substantive themes and relationships among primary-level codes. Cross-validation checks were used to establish trustworthiness and dependability.

Findings

Parent perspectives and the ways parents can be best supported in the transition process are discussed. Parents spoke about their involvement and the ways in which Head Start and Kindergarten teachers encouraged and supported their participation in the transition process. Parents also identified transition practices they felt most needed to be improved and their role in developing transition plans and working in partnership with Head Start staff and kindergarten teachers. Head Start and kindergarten teachers also spoke about the significance of parents' participation and the ways that they empower parents to get involved with their children's education and transition to Kindergarten. Particularly noteworthy findings include the comparison of parents', Head Start teachers', and kindergarten teachers' perceptions of the transition process and the factors within the transition process where they feel children and families could use assistance. The importance of preparing parents to act as their children's primary advocate within the school system will be highlighted. Contextual issues such as parents' own school experiences and cultural issues will also be described, based on both this study and the existing transition literature.

Conclusion

In this paper, we describe a team-based family-driven intervention that incorporated many "promising practices" in children's mental health. Many young children exhibit significant behavioral and emotional challenges yet do not receive the enhanced transition and service supports provided by

Early Childhood Special Education. These children are at risk of "falling through the cracks" when they transition from early childhood settings such as Head Start to kindergarten. Difficult transitions are associated with subsequent problems in school, both academically and behaviorally, making this a crucial point in the child's life. The T2K project worked collaboratively with parents, Head Start staff, and schools to identify and apply 'best practices' in transition services to support these children. The knowledge gained from the transition intervention will contribute to future design of transition supports for children and their families.

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Poster 26

Routine Screening to Identify Mental Health Problems in Pediatric Primary Care

Presenting: Jonathan Brown

Acknowledgements: We wish to thank the families and the staff of the participating clinics. Our research team included: Carmen Ivette Diaz, Mark Celio, O'Neil Costley, Xianghua Luo, Lucia Martinez, Nancy Tallman, Alexandra Suchman, Mei-Chen Wang, Nancy Weissflog. Primary data collection was supported by NIMH grant R01MH062469 (Dr. Wissow). This abstract received grant support from the Corporation for the Advancement of Policy Evaluation, Grant No. SG2008-003 (Dr. Brown). It reflects, however, the views and analysis of the authors and does not necessarily reflect those of CAPE.

Introduction

Routine screening in pediatric primary care has been proposed as a method to improve the identification of mental health problems. However, few pediatric primary care providers (PCPs) screen; 50% of PCPs have never used mental health screening tools (Gardner, Kelleher, Pajer, & Campo, 2003). and only 17% are interested in doing so (Olson et al., 2001). This is, in part, because PCPs have questions about how screening will affect their practice and whether screening will help to identify the needs of patients whose problems have historically been under-identified. These include racial/ethnic minority youth and youth with internalizing and "sub-threshold" disorders (Wren, Scholle, Heo, & Comer, 2003; Goldberg, Roghmann, McLerny, & Burke, 1984). A better understanding of whether screening could help to identify these populations may help to encourage screening and develop strategic collaborations with mental health specialists who can help PCPs manage mental health problems.

These descriptive analyses compared the characteristics of youth who demonstrated mental health problems on a standard screening tool with the characteristics of youth who were identified by their PCP as having a problem in the absence of screening information. Thus, these analyses were able to "simulate" the additional number of youth who would be identified as a result of screening.

Methodology

The data were collected to evaluate a training to improve PCPs' mental health communications skills (Wissow et al., 2008). Fifty-four PCPs from 16 sites participated. All served children ages infant to 18 years with a mix of insurance. 81% ($n = 44$) of PCPs were medical doctors, 16.6% ($n = 9$) nurse practitioners, and 1.8% ($n = 1$) was a physician assistant. 41% were male ($n = 22$), 64.8% ($n = 35$) pediatricians, and 35.2% ($n = 19$) family practitioners.

Interviewers approached all parents in the waiting areas of clinics from December 2002 to August 2005. The parent and child were eligible to participate if the child was 5-16 years old and the child's pain was 4 or less on a scale of 1-10. The parent provided written consent and children age 11 to 16 provided assent. Spanish instrumentation was used when appropriate. The parent was compensated \$15. The Johns Hopkins University School of Public Health Committee on Human Research and the ethics committees of clinics approved the procedures.

Of 871 child-parent dyads recruited, 4.9% refused or were ineligible. Of the remaining 828, 61 (7.4%) were missing data, resulting in a final sample of 767: 31.8% African-American, 56.3% Caucasian, and 13.0% Latino.

Measures

Following the visit, the PCP answered “Yes” or “No” to the question: “Is there a new, ongoing, or recurrent psychosocial problem?” based only on his or her clinical judgment.

Before the visit, the parent completed the Strengths and Difficulties Questionnaire (SDQ) to report their child’s symptoms during the past six months in five domains: emotions, conduct, inattention-hyperactivity, peer problems, and prosocial behavior. Domain/subscale scores range from 0-10. Subscales are summed to generate the Total Difficulties score, which ranges from 0-40. A five-item Impairment scale measures whether difficulties interfere with home life, friendships, classroom learning, and leisure; scores range from 0-10. Scores are categorized as low, medium, or high difficulties (Bourdon, Goodman, Rae, Simpson, & Koretz, 2005). Scores within the high difficulties range of each subscale and the total difficulties scale identify youth with the most severe symptoms. Scores within the medium difficulties range of each subscale and the total difficulties scale identify youth with moderate symptoms. Impairment scores of one or higher correspond to the 12% of the population with impairment.

Parents reported child race/ethnicity, gender, age, insurance, number of visits, and reason for visit.

Analysis

SDQ scores were computed using the standard algorithm. Proportions were used to examine the number of youth who demonstrated difficulties/symptoms and impairment on the SDQ with the proportion of youth identified by the PCP as having a problem in the absence of screening information.

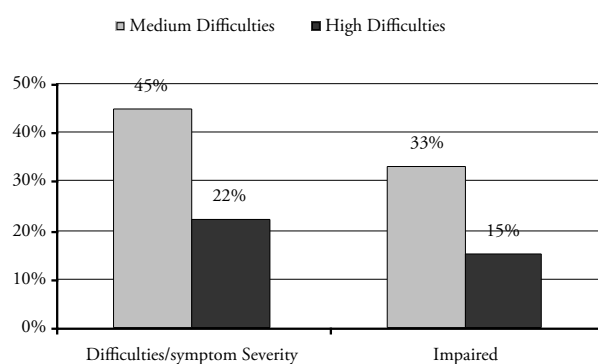
Findings

Identification and Symptoms/Impairment

Twenty-seven percent ($n = 211$) demonstrated high difficulties; 15.4% ($n = 118$) medium difficulties, and 35.3% ($n = 271$) impairment.

In the absence of screening information, PCPs failed to identify 45.1% of youth with medium difficulties and 22.3% with high difficulties (Figure 1). Thus, compared with PCP identification, using the SDQ would double the number identified as having medium difficulties and identify 28% more youth as having high difficulties. PCPs failed to identify 33.0% of impaired youth with medium difficulties and 15.2% of impaired youth with high difficulties (Figure 1).

Figure 1
Proportion of Children with Mental Health Difficulties and Impairment Not Identified by Provider



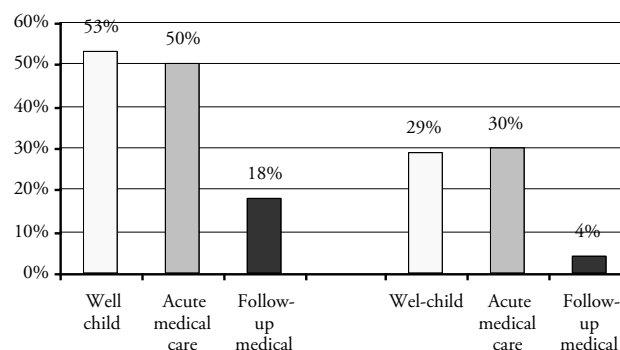
Internalizing versus Externalizing Symptoms

The difference in the number of youth identified by the screen compared with the PCP was unassociated with internalizing versus externalizing symptoms. Among youth with difficulties in only one domain, PCPs identified 41.7% with conduct symptoms, 61.3% with inattention-hyperactivity, 50.0% with emotion symptoms, 30.2% with peer relation problems, and 30.8% with low prosocial behavior.

Identification and Other Youth Characteristics

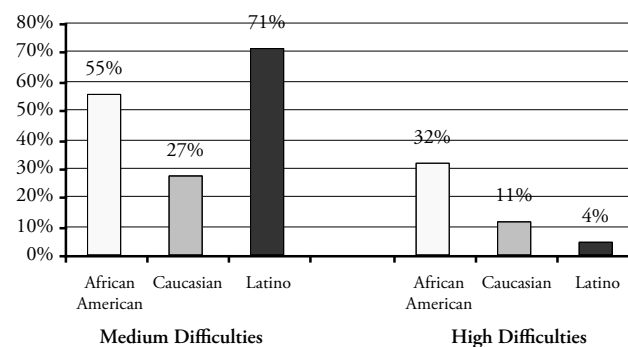
Compared with the screen, PCPs failed to identify 55.3% of youth with medium difficulties during well-child visits and 50.0% of youth with medium difficulties during acute medical visits compared with 17.6% during follow-up medical visits. Compared with the screen, PCPs failed to identify 29.2% of youth with high difficulties during well-child visits and 30.0% with high difficulties during acute medical visits compared with 4.3% during medical follow-up visits (Figure 2).

Figure 2
Proportion of Children with Mental Health Difficulties Not Identified by Provider: Differences by Reason for Visit



Compared with the screen, PCPs failed to identify 55.3% of African-Americans, 70.8% of Latinos, and 26.8% of Caucasians with medium difficulties. Compared with the screen, PCPs failed to identify 31.7% of African-Americans, 40.5% of Latinos, and 11.4% of Caucasians with high difficulties (Figure 3).

Figure 3
Proportion of Children with Mental Health Difficulties Not Identified by Provider: Racial and Ethnic Differences



Other characteristics were unassociated with the difference in the proportion of youth identified by the PCP and screen.

Conclusion

Routine screening in primary care may have the greatest potential to increase the identification of problems among (1) youth with moderate symptoms; (2) African American and Latino youth; and (3) visits for well-child or acute medical care.

Screening would substantially increase the number of youth suspected to have mental health problems. PCPs will likely need relationships with mental health specialists to manage the volume of children identified if screening is implemented. PCPs may particularly need assistance to address the needs of racial/ethnic minority youth and to determine whether intervention is necessary for youth with moderate symptoms.

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Poster 27

Hillsborough County's Civil Citation Project: Assessing Local Response to School-Related Justice Involvement

Presenting: Christopher J. Sullivan, Norin Dollard & John Mayo

Introduction

In 2004/2005, Hillsborough County led the state of Florida in school-based referrals to the Department of Juvenile Justice (JJ) with 18% of the County's total (12,936) originating in local schools (Office of Research and Planning, 2006). During the 2006/2007 Fiscal Year, 16% of the county's 11,957 referrals came from schools. Although this was a considerable decline (19.8%) from the 04/05 period, Hillsborough County still has the greatest number of school-based referrals statewide (Office of Research and Planning, 2008). When accounting for the size of the student population in that year, the County still ranked in the upper half of those statewide in school-based referrals (18 per 1,000 students).

Problem statement / research questions

Research suggests that diverting young offenders and at-risk youth from the juvenile justice system and into community-based programming will lead to reductions in further delinquent behavior (e.g., Regoli, Wilderman & Pogrebin, 1985; Shelden, 1999; Whitehead & Lab, 2001). Studies indicate that programs emphasizing family involvement and in-community programming have been successful in reducing later justice contacts (Foster, Qaseem, & Connor, 2004; Henggeler, 1997; Latimer, 2001; Lipsey, Wilson, & Cothorn, 2000; Sexton & Alexander, 2000; Shelden, 1998). This evidence makes the Civil Citation – Equal Justice Program (CCEJ), a newly implemented diversion program, a potentially attractive option for Hillsborough County's youth that commit misdemeanor crimes. The urgency of implementing such a diversion program for school-based referrals is underscored by the fact that both County (59%) and statewide (52%) figures suggest that the majority of school-based referrals represent the first such contact that the youth will have with the DJJ (Office of Research and Planning, 2008). Consequently, these referrals may serve as a gateway to future system involvement.

Purpose

This poster examines the implementation and some preliminary program outcomes related to the implementation of the CCEJ process in Hillsborough County Schools and the 13th Judicial Circuit of Florida. This initiative was intended to provide an alternative to school-based

justice referrals and reflects calls to reserve referrals only for the most serious offenses and develop alternative, graduated methods of dealing with school-based offenses (Skiba, Rausch, & Ritter, 2004).

Methodology

The research activities addressed:

Youth Characteristics. Youth are described in terms of socio-demographics, offense type and severity, referral source and program or entity with which they complete their community service.

Youth Diversion. To understand the effects of the CCEJ Program on the number and pattern of referrals, particularly disproportionate minority referrals, county-level trends are reviewed to assess changes over time. The referrals are also examined to assess the mandate that these efforts target high risk zip codes. Follow up data and information used to develop a matched sample of youth not enrolled in the CCEJ Program was obtained from JJ. A matched sample was developed based on key demographics (age, race, zip code, sex) and offense type(s). Youth are then assessed in terms of their program completion and future justice contact.

Network Development. A database containing the diversity of agencies involved was developed for programs that have agreed to serve as community service sites.

CCEJ Implementation. Stakeholder interviews were conducted concerning program operation, community perception, and specific areas for system and program improvement. A total of 14 interviews were conducted with key stakeholders from local agencies. Interviews were also conducted with personnel from designated community service sites. These data were then analyzed thematically to assess program development and assist in the future planning.

Preliminary Results and Anticipated Outcomes

Descriptive and outcome information for youth served in CCEJ were obtained from data maintained by Success for Kids & Families, Inc., who administers the program, as of June 30, 2008. Reports on case status are also current as of that date. The overall sample of CCEJ Youth comprised 563 cases at that time. Youth served in CCEJ are initially described below, followed by presentation of data in relation to some of the key project goals.

Overall, youth are predominantly male (64%). Their average age is about 14 years old with a range from 10 to 18 ($sd = 1.54$). They are most commonly in the 12 to 16 range. The population of youth included in the present analysis was predominantly White (56%) and Nonhispanic (73.7%). African Americans made up 43 percent of the population and Hispanics accounted for 26% of youth served.

The overwhelming majority of youth served (96%) successfully completed the required service hours. Most youth completed within 21 days of their offense. A number of those who did not complete their hours in a timely way were referred to court-based diversion services and subsequently successfully completed program requirements. Relatively few youth were considered to have failed to complete program requirements and were closed by CCEJ (1.2%) or diversion staff (2.3%). This level of program completion exceeds the initial goal offered by the community partners (90%). The prevalence of successful completion among those referred to court-based diversion suggests that this was a key aspect of that success as the percentage of youth with closed, unsuccessful cases likely would have exceeded 10 percent without that option.

It was expected that at least 50% of youth referred to the Civil Citation – Equal Justice Project resided in several targeted “high risk” zip codes. The top four zip codes in terms of rank are among those targeted. They account for a total of 29 percent of all referrals. Together, the nine high risk zip codes accounted for a total of 236 of the 553 cases for which this information was available (43%). So, while youth in the targeted zip codes made up a sizeable proportion of all cases, this was below the mark outlined in the project objectives.

In addition, information on further juvenile justice contact will be compared across youth involved in the program and matched comparison youth. It is expected that CCEJ involved youth will exhibit lower levels of further involvement with the justice system. Finally, qualitative data from key informant interviews will help to create a sense of the project’s development and its strengths and needs for adaptation and future improvement.

Poster 28

Consumer-Driven Evaluation and Youth Voice: The Inside-Outside Partnership for Massachusetts’ Transition Age Youth Initiative Program and Policy

Presenting: Joan Mikula & Evelyn Frankford

Introduction

Building on the central concept of consumer voice, the Massachusetts (MA) Department of Mental Health (DMH) created an inside-outside partnership with consumer and peer-run organizations to prioritize a policy of developing a Statewide Transitional Age Youth (TAY) Initiative to address the needs of youth and young adults ages 16 to 25 with serious mental health needs (Delman 2002; Delman 2009). With active youth and consumer leadership, MA DMH garnered legislative support to deploy new and restructured resources in each of the state’s service areas, based on the Transition to Independence Process (TIP) framework (Clark & Davis, 2000). After redesigning supported housing, supported employment, and case management in response to consumer recommendations and creating a statewide system of supports that includes community wraparound services, specialized treatment and peer mentoring, the MA DMH TAY Initiative is now working on policy to establish TAY as a priority population by implementing a Memorandum of Understanding across state agencies, with particular emphasis on helping them complete high school, and through implementation of remedy to the lawsuit Rosie D. MA DMH and its key partners The

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Transformation Center, a peer-operated center, and the Statewide Youth Advisory Council, are supporting outreach efforts, via YouTube videos and other media, to engage greater numbers of minority youth in innovative programming and to ensure their satisfaction. Strategies that contributed to this success in a challenging fiscal environment are summarized and examples of peer-to-peer engagement with diverse youth are presented.

Methodology

The Youth Voice, Program, and Policy Loop to Build a Partnership

Key factors for success in creating Massachusetts’ Statewide TAY Initiative have been (1) the partnership between a strong youth and young adult community supported by older “system graduates” serving as mentors and active state leadership, and (2) the partnership’s ability to insert TAY principles into existing state policy and program inter-agency initiatives.

An initial 2002 study of the significant challenges facing adolescents who have “aged out” of the mental health system, undertaken by the consumer-directed non-profit organization Consumer Quality Initiatives (CQI), recommended that the State “initiate and support five initial

steps called for by our cohort: (1) Skill-building and education responsive to individual needs, (2) Age-appropriate services/housing, (3) Peer mentoring, (4) Youth in transition website, and (5) Development of youth advocacy program (Delman, 2002).

As the State Mental Health Authority, DMH sets policy and assures and provides access to services and supports to meet the mental health needs of individuals of all ages, enabling them to live, work and participate in their communities. In 2002, DMH's State Planning Council created a Standing Committee on Transition Age Youth, the Youth Development Committee (YDC), co-chaired by young adults. Working in partnership with the YDC is the Statewide Youth Advisory Council (SYAC), staffed by the Statewide Youth Coordinator, which educates young adults on services and supports, offers training on advocacy and leadership, and coordinates youth involvement in program monitoring and evaluation. In conjunction with DMH's Transformation Center, the SYAC was recently awarded a SAMHSA grant to fund a year-long process to create a professional quality film about minority transition age youth in recovery, in order to provide access to recovery for such populations and address public opinion about mental health in minority communities. African-American youth are 6% of Massachusetts' 15-24 year old population but 14% of the DMH TAY population.

Based on the Transition to Independence Process (TIP) framework, DMH created new initiatives in every area of the state to improve services for the transition age population (16-25): housing services, education and vocational services, career and employment services, community rehabilitation support, youth centers, clubhouses, flexible support and wraparound services, youth development and family support, Assertive Case Management (ACT) programs, as well as peer mentoring. DMH redesigned supported housing, supported employment, and case management to better appeal to this group and created a statewide system of supports that also includes community wraparound services, specialized treatment and peer mentoring.

The most comprehensive interagency work on youth from birth to 21 is implementation of the remedy for the Rosie D. lawsuit, which will significantly increase access to intensive community-based services for children with serious emotional disturbance who are enrolled in MassHealth, Massachusetts' Medicaid program. DMH chairs the Interagency Workgroup for Rosie D. implementation, now known as the Children's Behavioral Health Initiative (CBHI). Additional inter-agency work is in progress as a result of the June 2008 Governor's education reform initiative to improve high school graduation rates and ensure access to post-secondary education, including community college, for all students, in order to prepare all youth for the economy of the future (Ready for 21st Century Success: The New Promise of Public Education, June 2008). That initiative states that MA's approach to education "will proceed only by serving the individual needs of the student."

Findings

Inside-Outside Partnership of Youth Voice and Peer Mentoring with State Leadership in Program Development and Policy

Using the TIP framework as the organizing principle to reorganize services, MA DMH began a TAY Initiative that emphasizes program, policy, and an inside-outside partnership with youth voice and peer outreach in the six mental health service areas across the state. DMH built also on program opportunities for community-based case management and crisis intervention components via the Rosie D. lawsuit remedy, now the Children's Behavioral Health Initiative. With youth involvement, MA DMH has engaged policy via the Governor's 2008 education plan and is working to craft an inter-agency Memorandum of Understanding (MOU) to improve educational and vocational outcomes for TAY. Federal grants and state support were garnered to ensure that youth partners would have a strong voice and pursue outreach to engage minority youth, who are overrepresented in the mental health system. Youth have created video materials for YouTube to engage diverse peers. A 2009 draft of a CQI evaluation of two programs for the TAY population states that "overall, consumer experiences with both programs were positive. Respondents' overall satisfaction is evident from the strong relationships with a clinician (therapist or psychiatrist) and being in a safe and comfortable environment." MA DMH has "closed the loop" from a youth-stimulated initiative through program development through policy promotion and back to youth outreach and consumer evaluation of its system via an inside-outside partnership.

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Poster 29

Emotional and Academic Outcomes for Students in a School-Based Partial Hospitalization Program

Presenting: Ron V. Prator

Overview

Colonial Intermediate Unit 20 (CIU 20) is a regional service agency located in northeastern Pennsylvania. CIU 20 provides service to thirteen school districts located in Pike, Monroe, and Northampton counties.

One of the departments within the CIU 20 agency is the RESOLVE Behavioral Health program. For the past fifteen years, RESOLVE has operated a series of school and home-based mental health programs. These programs are located on different points of the service continuum; ranging from less restrictive to more restrictive.

The current proposal focuses on one program within the RESOLVE family, the Partial Hospitalization Program (PHP). RESOLVE currently maintains twenty-two partial hospitalization sites; each of them located in a public school building. Each individual site is a licensed mental health program considered to be the most intensive level of programming before inpatient hospitalization or residential treatment.

Each site is capable of providing service for up to ten students. Services provided include individual therapy, group therapy, family therapy, psychiatric services, and case management. Each PHP site is staffed by four professionals; a Masters-level therapist, a special education teacher, a Bachelors-level therapist, and a paraprofessional. These four professionals are expected to develop and implement a curriculum that jointly meets the mental health and educational needs of the student. Two important aspects of the RESOLVE philosophy are the use of a collaborative approach and the use of Solution-Focused Therapy (SFT). A menu of empirically-based treatment protocols are available to the therapists to supplement the tailored treatment plan developed by the treatment team (student, family, PHP staff, psychiatrist, county case managers, etc.).

Outcomes Measurement

For the past fifteen years, RESOLVE has made attempts to measure educational and treatment outcomes. As the RESOLVE program matured, so did the approaches in measuring outcomes. Currently, RESOLVE uses the Child Behavior Checklist (CBCL), the Wechsler Individual Achievement Test-II (WIAT-II), and the Child and Adolescent Functional Assessment Scale (CAFAS) to measure outcomes. The use of these inventories allows for the parents' perspective, the therapist's perspective, and degree of educational progress to all be considered in the clinical decision-making process.

Part of the intent of this presentation is to convey to the reader some of the difficulties in initiating, monitoring, and maintaining a data collection system. Personnel, resources (computers, software), time, and money all need to be allocated for this purpose. Staff may need to be trained, timelines established, and processes for the delivery and return of materials will need to be outlined. When implementing a data collection system, agencies should be prepared for their corporate culture to be challenged at some level, for some staff not to have insight into the purpose and meaning of measuring outcomes, and for the reality of

the everyday functioning of the agency to potentially conflict with the methods established for data collection. The issue of measuring outcomes is not a superficial one. Planning for outcomes will lead to discussions about mission and purpose, intake procedures, fidelity to treatment protocols, consistency across sites, discharge procedures, and the needs of stakeholders. All of these challenges can be worked through provided the agency has made the commitment to assessing the health of their program through documenting outcomes.

Results

Results of the CBCL indicate that of the 306 students who were rated on this instrument, 228 met the criteria for inclusion in the study (CBCL completed 30 days +/- admission date). 81% of the students included in the study scored in the Clinical range on the Total Problems scale with an additional 7% scoring in the Borderline range. From Time 1 (30 days +/- admission) to Time 2 (6-12 months after Time 1) changes were noted on a majority of the clinical scales; however, these changes did not rise to the level of clinical significance. From Time 1 (30 days +/- admission) to Time 3 (12-18 months after Time 1) statistically significant changes ($p < .05$) were noted on 11 of the 15 scales.

Results from the WIAT indicate that of the 298 students who were assessed using this instrument, 234 met the criteria for inclusion in the study (WIAT completed 30 days +/- admission date). Baseline data indicated that students, on average, were behind in Reading (.5 grade level), behind in Spelling (1.0 grade level), and behind in Math (2.0 grade levels). From Time 1 (30 days +/- admission) to Time 2 (6-12 months after Time 1) statistically significant changes ($p < .05$) were noted in all three academic areas. From Time 1 (30 days +/- admission) to Time 3 (12-18 months after Time 1) statistically significant changes ($p < .05$) continued. During the time spent in the partial hospitalization program, students progressed an average of .9 grade level in Spelling, 1.1 grade level in Reading, and 1.9 grade level in Math.

Results from the CAFAS indicate that of the 319 students assessed on this instrument, 159 met the criteria for inclusion in the study (CAFAS completed 30 +/- admission date). Baseline data indicated that one scale (School/Work) was in the Severe range while three other scales (Behavior Toward Others, Moods/Emotions, and Home) were in the Moderate range. From Time 1 (30 days +/- admission) to Time 2 (3-7 months from Time 1) statistically significant changes ($p < .05$) were seen on 6 of 9 scales. From Time 1 (30 days +/- admission) to Time 3 (6-10 months after Time 1) statistically significant changes ($p < .05$) were noted on 7 of 9 scales.

Conclusion

It is believed that the data showed a proper utilization of service, as evidenced by the clinical need demonstrated on the CBCL. The data also suggests that students show an improvement in mental health functioning, academic performance, and daily functioning as a result of the services provided. Efforts need to be made to have more data in compliance with the timelines established for baseline and follow-up measures and thereby have more students' scores included in the analysis.

Poster 30

Critical Components for Developing and Sustaining School-Based Family Peer Support Programs

Presenting: Olivia Davis, Kelly Grubbs, Joi Barkley & Lori Crosby

Introduction

Navigating the mental health care system can be quite intimidating and overwhelming for families, especially those with limited resources. Schools play a key role in the identification of mental health problems and are in a unique position to assist parents with obtaining mental health services. School programs that provide this assistance are referred to as parent to parent support programs. The premise behind these programs is that “parents coping with children with a variety of problems (e.g. mental health and chronic illness) and parents who have shared a similar experience [and] can offer support in various forms” (Effective Strategies, 2008). Parent to parent support programs have been found to be effective in increasing service initiation (Elliott, Koroloff, Koren & Friesen, 1998) and empowering parents; yet little is known about the key strategies that make these programs effective (Effective Strategies, 2008).

This presentation will identify critical components for developing and sustaining a school based family peer support program. Components such as agency identification, school selection, securing funding, hiring, training and supervising family peer support workers, and developing an evaluation system will be discussed in light of program outcomes and lessons learned from The Family Peer Support (FPS) Program in Hamilton County, Ohio.

Methods and Critical Components

Agency Identification

Agencies that have experience working in the schools and a positive school presence should be considered. The Center for Children and Families and Beech Acres Parenting Center were identified as lead agencies for this program due to their track record in family-oriented programming and training culturally diverse workers, as well as experience collaborating with Hamilton County schools.

School Selection

Schools should be selected as sites for an FPS program based on a number of criteria including: school and student readiness, school request for services, family responsiveness, sustainability, geography, and current relationship/capacity. The FPS operates in 10 schools. The program has been most effective in schools with high needs for mental health services and experience collaborating with outside agencies.

Funding an FPS Program

A school-based FPS program can be implemented utilizing ABC funding and local dollars from the County Mental Health Board. The majority of funds will be allocated to salaries, benefits and training of the FPS staff. Funds should also be utilized to provide parenting events and outreach activities.

Hiring, Training and Supervising FPS Workers

FPS workers should come from a variety of educational and professional backgrounds and be selected based on their interest in the program, experience working with others (e.g. customer service, human service), willingness to complete extensive training (agency orientation, parental engagement, advocacy, systems resources and navigation, etc.) and experience accessing behavioral health care, educational, or juvenile justice services for their own families.

Program Implementation

Outreach. FPS staff should strategically place themselves at school functions to increase visibility, talk to families about the program, and collect baseline needs assessment data. Other outreach/marketing activities may include mailings and sponsoring breakfasts and lunches for teachers and parents.

Referral Process. FPS staff members should utilize a referral script to help them introduce the program to parents and describe prevention services.

Linking Parents to Community Resources. The program should partner with the school and serve as a parent resource center for the community. The Hamilton County FPS sites have become parent resource centers and are equipped with a computer kiosk for internet access and a binder of resources. The FPS also hosts parent trainings, roundtable discussions, family events and resource fairs.

Developing an Evaluation System

It is essential that programs develop measurable outcomes and develop a streamlined data collection process.

Program Outcomes. Outcomes should focus on three areas: (1) increasing service initiation, (2) parent empowerment, and (3) social support.

Data Collection Process. A web-based data collection system may be a user-friendly way to collect and manage data for an FPS program. The Hamilton County FPS program tracks referrals, contacts, survey and outcome data through a confidential web-based assessment portal. FPS workers collect hard copy forms and enter them into the web-based system. Program data are then analyzed by an independent evaluator (i.e., INNOVATIONS in Community Research).

Findings/Program Outcomes

Program data should be presented to funders, agency personnel, school administrators and FPS workers. Data should be provided on the number of parents served, FPS staff retention, access to services, types of services provided and impact on parents. The Hamilton County FPS program delivered services to 728 families. Seventy percent of FPS staff who were recruited in year one of the program remained involved with the program throughout the 2007-2008 school year. Program outcomes related to service initiation and parental empowerment and support are summarized below:

Program Goal 1: Increase access to behavioral health services for children involved in juvenile court, child welfare, education and/or primary health care system.

Outcomes:

- 78.9% of parents reported increasing their awareness of behavioral health care/community resources
- 73.2% of parents reported learning how to access behavioral health care programs and services
- 60.6% of parents reported being better able to support their child's learning and positive behavior

Program Goal 2: Increase parental support and ability to meet child's needs.

Outcomes:

- 78.9% of parents reported being able to get needed services for their child/family
- 62% of parents reported that they built a support network for their child/family
- 60.6% of parents reported being better able to meet their child's social and emotional needs
- 83.1% of parents reported strengthening their support network

Conclusion

A school-based FPS program is effective in increasing service initiation and empowering and supporting parents. Specifically, the Hamilton County FPS program data show positive trends in parents' reported awareness, availability, and utilization of resources. This presentation will critical components for developing an effective school based FPS program. Family-guided programs like those in Hamilton County provide a feasible and cost-effective alternative for helping parents obtain needed services for children with severe emotional disturbances.

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Wednesday Intensive Workshops » March 4 » 9:00 am

Intensive 2—Salon A/B

Concept Mapping as a Next Generation, Multi-Use Strategy

Lenore Behar, Director, Child & Family Program Strategies, Durham, NC; Marty Hydaker, Hydaker Community Counseling, Cullowhee, NC; and Robert Paulson, Professor, Dept. of Child and Family Studies, Louis de la Parte Florida Mental Health Institute, University of South Florida

This session provides an introduction to the method of Concept Mapping, including the mechanics of the process, both Internet-based and face-to-face. In addition to describing concept mapping's use in program evaluation and evaluation of specific practices such as Wraparound, the workshop will also look at how this method can be used at the community level to determine essential characteristics, such as readiness for implementing systems of care. Through real life examples, presenters will demonstrate how Concept Mapping is used for community engagement, planning, and as the basis for logic models. Participants will be equipped with strategies for utilizing these approaches in their communities to support development of effective systems of care.

Intensive Workshop 3—Salon C/D

Building the Research Base: Grant Funding Opportunities at the Institute of Education Sciences (a.k.a. "Show Me the Money")

Jackie Buckley, Program Officer, National Center for Special Education Research

This workshop will provide attendees with an opportunity to learn about available funding opportunities through the National Center for Special Education Research and National Center for Education Research within the Institute of Education Sciences. The Centers seek research applications designed to examine ways to improve student outcomes through identifying, developing, and validating effective education programs, practices, policies, and approaches as well as understanding the factors that influence variation in their effectiveness such as implementation. The intent of this workshop is to provide potential applicants with an overview of the current research grant opportunities available through the research Centers. After providing an overview of the programs, Dr. Buckley will discuss in detail the components of successful grant applications, and will provide opportunities for potential applicants to ask questions about the grant application process.

About our Presenters

Presenter List

Halima A. Al-Khattab, BS, CT(ASCP), SN

Indiana University School of Nursing
1448 West Lynn Drive
Indianapolis IN 46202
317-427-3444
habdurra@iupui.edu

Malena Albo

National Director of Cultural Competence
Public Sector, Magellan Health Services
1225 E. Broadway Road Suite 190
Tempe AZ 85282
602-653-6214
malbo@magellanhealth.com

Myra Alfreds, MSW

Director
Children's Mental Health Services, Westchester
County Department of Community Mental Health
112 East Post Road, 2nd Floor
White Plains NY 10601
914-995-5250, fax: 914-995-6220
mvv4@westchestergov.com

Pamela R. Alger, LMSW

Bureau Chief of Child and Adolescent Services,
Mental Health and Disability Services
Iowa Department of Human Services
1305 East Walnut Street, Hoover Building, Fifth Floor
Des Moines IA 50319
515-281-3234, fax: 515-242-6036
palger@dhs.state.ia.us

Stacey Alicea, MPH

Senior Project Director
Dept. of Psychiatry & Community Medicine,
Mount Sinai School of Medicine
One Gustave L. Levy Place Box 1230
New York NY 10029
212-659-8790, fax: 212-659-8940
Stacey.Alicea@mssm.edu

Borja Alvarez de Toledo, MEd

Vice President for Operations
The Guidance Center, Inc.
5 Sacramento Street
Cambridge MA 02138
617-354-2275, fax: 617-547-4356
btoledo@gcinc.org

Ilana Amrani-Cohen, MSW, PhD

Director of Domestic Violence Services
Child and Youth Guidance Clinic, The Guidance
Center, Inc.
5 Sacramento Street
Cambridge MA 02138
617-354-2275, fax: 617-547-4356
icohen@gcinc.org

Ross Andel, PhD

Assistant Professor
School of Aging Studies,
University of South Florida
4202 East Fowler Ave., MHC1321
Tampa FL 33620
813-974-9743, fax: 813-974-9754
randel@cas.usf.edu

René Anderson

Human Services Program Specialist
Child and Family Studies
Louis de la Parte Florida Mental Health Institute
University of South Florida
13301 Bruce B. Downs Blvd.
Tampa FL 33612
813-974-2199, fax: 813-974-7376
randerso@fmhi.usf.edu

Mary Armstrong, PhD

Assistant Professor
Department of Child and Family Studies
Florida Mental Health Institute
University of South Florida
13301 Bruce B. Downs Blvd
Tampa FL 33612
813-974-4601, fax: 813-974-7376
armstron@fmhi.usf.edu

Melissa J. Azur, PhD

Assistant Scientist
Mental Health, Johns Hopkins Bloomberg School
of Public Health
624 N. Broadway, HH801
Baltimore Maryland 21205
410-502-8506
mazur@jhsph.edu

Harold R. Baize, PhD

Evaluator
Behavioral Health, Butte County
109 Parmac, Suite 1
Chico CA 95926
530-895-6554
hbaize@buttecounty.net

Ayesha Bajwa

Director
Maryland Choices
5 Choke Cherry Rd., Suite 280
Rockville MD 20850
301-947-0023, fax: 301-947-0199
abajwa@choicesteam.org

Janis Bane, MS

Project Director
Systems of Hope
6300 Chimney Rock Road
Houston TX 77081
713-795-4673, fax: 713-295-2522
janis.bane@cps.hctx.net

William M. Bannon, Jr., PhD

Assistant Professor
Department of Community and Preventive
Medicine, Mount Sinai School of Medicine
One Gustave L. Levy Place, Box 1230
New York NY 10029
212-241-3707, fax: 212-348-1170
william.bannon@mssm.edu

Joi Barkley, EdD

Consultant
INNOVATIONS in Community Research and
Program Evaluation, Cincinnati Children's Hospital
Medical Center
3333 Burnet Avenue, MLC 3015
Cincinnati OH 45229
513-636-3739, fax: 513-636-7400
Joi.Barkley@cchmc.org

Crystal L. Barksdale, PhD

Post Doctoral Fellow
Mental Health, Johns Hopkins Bloomberg School
of Public Health
624 N. Broadway, Room 808
Baltimore MD 21205
410-502-9344
cbarksda@jhsph.edu

Melanie Barwick, PhD C.Psych

Community Health Resource Group, Hospital for
Sick Children
555 University Avenue
Toronto ON M5G 1X8 Canada
416-813-1085
melanie.barwick@sickkids.ca

Marion Becker, PhD, RN

Professor
Aging and Mental Health
University of South Florida
13301 Bruce B. Downs Blvd
Tampa FL 33612
813-974-7188, fax: 813-974-6411
becker@fmhi.usf.edu

Lenore Behar, PhD

Director
Child & Family Program Strategies
1821 Woodburn Road
Durham NC 27705
919-489-1888
lbehar@nc.rr.com

Michael A. Bengtson, MD

Chief Child and Adolescent Psychiatry
Psychiatry, University of South Florida
3515 E Fletcher Ave.
Tampa FL 33613
813-974-5926, fax: 813-974-3223
mbengtso@health.usf.edu

Adam Bernstein, MA

Graduate Student
Psychology, UCLA
1285 Franz Hall
Los Angeles CA 90095
310-206-5895
bernstein@ucla.edu

David Bernstein, PhD

Director
The Center for Effective Interventions,
Metropolitan State College of Denver
900 Auraria Parkway, Suite 129
Denver CO 80204
303-352-4203, fax: 303-352-4201
bernstei@mscd.edu

Ilene R. Berson, PhD

Associate Professor
Childhood Education & Literacy Studies,
University of South Florida
4202 E. Fowler Ave., EDU 105
Tampa FL 33620
813-974-7698, fax: 813-974-0938
iberson@coedu.usf.edu

Rosalyn M. Bertram, PhD

Assistant Professor
School of Social Work, University of Missouri-
Kansas City
10817 Oak Street
Kansas City MO 64114
816-943-1909, fax: 816-235-6573
bertramr@umkc.edu

Cynthia S. Blacklaw, MS

Executive Director
Children's Home Society of FL Western Division
1300 N. Palafox St. Suite 103
Pensacola FL 32501
850-266-2700, fax: 850-595-0180
Cynthia.blacklaw@chsfl.org

Betty Blackmon, MSW, JD

Assistant Professor
Social Work, University of Missouri Kansas City
4825 Troost
Kansas City Missouri 64110
816-235-1089
blackmonb@umkc.edu

Andrea K. Blanch, PhD

Sarasota FL
akblanch@aol.com

Katrina L. Bledsoe, PhD

Manager
Walter R. McDonald & Associates
12300 Twinbrook Parkway, Suite #310
Rockville MD 20852
301-881-2590, fax: 301-881-0096
kbledsoe@wrma.com

Roger A. Boothroyd, PhD

Professor
Florida Mental Health Institute, University of
South Florida
13301 Bruce B. Downs Blvd.
Tampa FL 33612
813-974-1915, fax: 813-974-9327
boothroyd@fmhi.usf.edu

Diana Born, MEd

Counselor IV
Trauma Recovery Initiative, Children's Home
Society of FL Western Division
1300 N. Palafox St. Suite 103
Pensacola FL 32501
850-266-2700, fax: 850-595-0180
Diana.Born@chsfl.org

Robyn Boustead

Missouri Institute of Mental Health
Dept of Mental Health 1706 E. Elm
Jefferson City MO 65102
573-751-8724
robyn.boustead@dmh.mo.gov

Jeana Bracey, MA

Predoctoral Fellow
Connecticut Center for Effective Practice
270 Farmington Ave., Suite 367
Farmington, CT 06032
Phone: 860-679-1524
Fax: 860-679-1521
jeana.bracey@yale.edu

Bonnie Brandt, MA

Evaluator
CEDDERS, University of Guam
Deans Circle, House #12
Mangilao Guam 96923
671-735-2398, fax: 671-734-5709
bbrandt@ite.net

Ana Maria Brannan, PhD

Senior Research Associate
Center for Evaluation and Program Improvement,
Vanderbilt University
Peabody #151, 230 Appleton Place
Nashville TN 47401
812-322-3473
ana.m.brannan@vanderbilt.edu

Freda L. Brashears, MSW

Project Manager
Macro International Inc.
3 Corporate Square, Suite 370
Atlanta GA 30329
404-321-3211, fax: 404-321-3688
freda.l.brashears@macrointernational.com

Eileen M. Brennan, PhD

Principal Investigator
Research and Training Center on Family Support
and Children's Mental Health, Portland State
University
P.O. Box 751
Portland OR 97207
503-725-4040, fax: 503-725-4180
brennane@pdx.edu

Teri S. Brister, PhD., LPC

Director
NAMI Programs for Young Families
105 Shenandoah Estates Circle
Brandon MS 39047
601-829-0591, fax: 601-829-0347
tbrister@nami.org

Jacquie Brown, M.E.S.

Director, Programme Services
Kinark Child and Family Services
500 Hood Road
Markham ON L3R 9Z3 Canada
905-474-9595
jacquie.brown@kinark.on.ca

Jonathan D. Brown, PhD, MHS

Researcher
Mathematica Policy Research, Inc.
600 Maryland Ave SW Suite 550
Washington DC 20024
202-264-3446, fax: 202-863-1763
jbrown@mathematica-mpr.com

Renee R. Brown

Psychology, University of South Florida
5902 Memorial Hwy apt 1214
tampa FL 33615
813-784-1641
reneeb222@hotmail.com

Linda Broyles

Deputy Director
Southeast Kansas Community Action Program, Inc.
411 N. Sinnet
Girard KS 66743
620-724-8204, fax: 620-724-4471
lindab@sek-cap.com

Eric J. Bruns, PhD

Associate Professor
Division of Public Behavioral Health and Justice
Policy, University of Washington School of Medicine
2815 Eastlake Ave E, Suite 200
Seattle WA 98102
206-685-2477, fax: 206-685-3430
ebruns@u.washington.edu

Barbara J. Burns, PhD

Professor of Medical Psychology
Department of Psychiatry and Behavioral Sciences,
Duke University School of Medicine
Box 3454 DUMC
Durham NC 27710
919-687-4676, fax: 919-687-4737
bjb@geri.duke.edu

Geraldine Burton, FDC

Parent Advocate/Co-Project Director
Clinical Psychology and Psychiatry, Columbia
University/NY State Psychiatric Institute
1051 Riverside Dr.
New York NY 10032
212-342-5346, fax: 212-342-0120
BurtonG@childpsych.columbia.edu

Linda M. Callejas, MA

Social and Behavioral Researcher
Child & Family Studies, University of South Florida
13301 Bruce B. Downs Blvd., MHC 2315
Tampa FL 33612
813-974-4640, fax: 813-974-7563
callejas@fmhi.usf.edu

Claudine Cannezzaro

Director of In-Home Family Services
3111 S. Dixie Highway, Suite 200
West Palm Beach FL 33405
561-366-9400 x228
CannezzaroC@boystown.org

Ann Capoccia

Coordinator, Interagency Activities, Child/Adolescent
Services
MA Department of Mental Health
25 Staniford St
Boston MA 02114
617-626-8080
Ann.Capoccia@state.ma.us

Bill Carter, LCSW

Assistant Director
California Institute for Mental Health
2030 J Street
Sacramento CA 95814
916-556-3480x130
bcarter@cimh.org

Brady G. Case, MD

Leon Levy Research Assistant Professor
Child and Adolescent Psychiatry, New York University
School of Medicine
Nathan Kline Institute, 140 Old Orangeburg Road
Orangeburg NY 10962
917-697-2890
bcase@nki.rfmh.org

Valencia Cash

Office of Behavioral Research and Evaluation,
Arkansas State University
PO Box 1560
State University AR 72467
870-972-2287, fax: 870-972-3071
obre@astate.edu

Karen Castellanos-Brown, MSW

Graduate Research Assistant, PhD student
Social Work, University of Maryland, Baltimore
8 Charles Plz, Apt 1207
Baltimore MD 21201
410-807-6991
kcastellanos@ssw.umaryland.edu

Mary A. Cavaleri, PhD

Assistant Professor
School of Social Work, Hunter College
129 E. 79th Street, Room 540
New York NY 10075
212-452-7144
mary.cavaleri@hunter.cuny.edu

Doreen A. Cavanaugh, PhD

Research Associate Professor
Health Policy Institute, Georgetown University
3300 Whitehaven St., NW, Suite 5000, Box 571444
Washington DC 20057
202-687-0634, fax: 202-687-3110
dacemail2@aol.com

Shweta Chandra, MSW

Research Assistant
Indiana University School of Social Work, Indiana
Division of Mental Health & Addiction
402 W. Washington St., W353
Indianapolis IN 46204-7907
317 232-7872, fax: 317 233-3472
Shwetachandra10@yahoo.com

Huey-Jen Chen, PhD

College of Nursing, Georgia State University
Atlanta GA 30302
nurhjc@langate.gsu.edu

Susan Chinitz, Psy.D.

Director, Associate Professor of Clinical Pediatrics
The Early Childhood Center, Albert Einstein
College of Medicine
1731 Seminole Avenue
Bronx NY 10461
718-430-8900, fax: 718-892-4736
suechinitz@aol.com

J. J. Choi, MSW, PhD

Assistant Professor
Social Welfare Department,
Florida Atlantic University
44, 284
Boca Raton, FL 33431
616-297-6494
jchoi@fau.edu

Wai-Ying Chow, PhD

Postdoctoral Fellow
Psychiatry/Division of Child & Adolescent
Psychiatry, University of Maryland School of
Medicine
737 W. Lombard Street
Baltimore MD 21201
410-706-4726, fax: 410-706-6220
wchow@psych.umaryland.edu

Annette Christy, PhD

Associate Professor
Mental Health Law and Policy
University of South Florida
13301 Bruce B. Downs
Tampa, FL 33612
813-974-7419, fax: 813-974-6411
achristy@fmhi.usf.edu

Hewitt "Rusty" B. Clark, PhD

Professor and Director National Network on Youth
Transition for Behavioral Health
Department of Child and Family Studies,
Florida Mental Health Institute, University of
South Florida
13301 Bruce B. Downs Blvd., MHC 2332
Tampa FL 33612
813-974-6409, fax: 813-974-6257
clark@fmhi.usf.edu

Anthony Cobos, BBA

El Paso County Judge
Office of the County Judge, El Paso County
500 E. San Antonio
El Paso TX 79001
915-546-2000
lmarcena@epcounty.com

Kari Collins, PhD

Kentucky Department for Mental Health,
Developmental Disabilities and Addiction
Services
100 Fair Oaks Lane 4E-D
Frankfort KY 40621
502-564-4456
kari.collins@ky.gov

Christian M. Connell, PhD

Assistant Professor
Department of Psychiatry, Yale University School
of Medicine
389 Whitney Ave.
New Haven CT 06511
203-789-7645, fax: 203-562-6355
christian.connell@yale.edu

James R. Cook, PhD

Associate Professor
Psychology, The University of North Carolina at
Charlotte
9201 University City Blvd
Charlotte NC 28223
704-687-4758, fax: 704-687-3096
jcook@uncc.edu

Nancy L. Craig, AA

Parent Advisor
Division of Children and Families, New York State
Office of Mental Health
737 Delaware Avenue, Suite 200
Buffalo NY 14209
716-432-6238, fax: 716-885-4096
cocfnc@omh.state.ny.us

Lori Crosby, PsyD

Associate Professor
Division of Pediatrics, INNOVATIONS in
Community Research, Cincinnati Children's
Hospital Medical Center
3333 Burnet Ave, MLC 3015
Cincinnati OH 45229
513-636-5380, fax: 513-636-7756
Lori.Crosby@cchmc.org

Terry L. Cross, MSW

Executive Director
National Child Welfare Association
5100 SW Macadam Ave, Suite 300
Portland OR 97239
503-222-4044, fax: 503-222-4007
terry@nicwa.org

Cindy A. Crusto, PhD

Assistant Professor
Psychiatry, Yale University School of Medicine
389 Whitney Ave.
New Haven CT 06511
203-789-7645
cindy.crusto@yale.edu

Charles E. Cunningham, PhD

Professor
Department of Psychiatry and Behavioural
Neurosciences, McMaster University
Room G19, 354 King Street West
Hamilton ON L9P 1B3 Canada
905-521-2100 x 77307, fax: 905-577-8465
cunnec@hhscc.ca

Amy M. Daniels, MHS

Doctoral student
Department of Mental Health, Johns Hopkins
Bloomberg School of Public Health
614 N. Broadway, Room 839
Baltimore MD 21205
203-984-5925
adaniels@jhsph.edu

Maryann Davis, PhD

Research Associate Professor
Center for Mental Health Services Research,
Dept. of Psychiatry,
University of Massachusetts Medical School
55 Lake Avenue
Worcester MA 01655
508-856-8718, fax: 508-856-8700
maryann.davis@umassmed.edu

Olivia Davis, BA

Research Assistant III
INNOVATIONS in Community Research and
Program Evaluation,
Cincinnati Children's Hospital Medical Center
3333 Burnet Avenue, MLC 3015
Cincinnati OH 45229
513-636-3739, fax: 513-636-7400
Olivia.Davis@cchmc.org

Mark B. DeKraai, Ph. D., JD

Project Director
University of Nebraska Public Policy Center
215 Centennial Mall South
Lincoln NE 68588
402-472-1496
mdekraai@nebraska.edu

Shyanne Depriest

Black Family Development, Inc.
2995 East Grand Boulevard
Detroit MI 48202
313-420-9016

Nicole Deschênes, MEd

Professor and Co-Director National Network on
Youth Transition for Behavioral Health
Department of Child and Family Studies, Florida
Mental Health Institute, University of South
Florida 13301 Bruce B. Downs Blvd.
13301 Bruce B. Downs Blvd.
Tampa FL 33612
813-974-4493, fax: 813-974-6257
deschenes@fmhi.usf.edu

Jennifer D. Dewey, PhD

Technical Director
Macro International Inc.
3 Corporate Square, Suite 370
Atlanta GA 30329
404-321-3211, fax: 404-321-3688
jennifer.dewey@macrointernational.com

Daniel L. Dickerson, DO, MPH

Assistant Research Psychiatrist
UCLA, Integrated Substance Abuse Programs
1640 S. Sepulveda Blvd., Suite 200
Los Angeles CA 90025-7535
562-277-0310, fax: 562-433-8292
daniel.dickerson@ucla.edu

Norin Dollard, PhD

Assistant Professor
Child and Family Studies, Louis de la Parte Florida
Mental Health Institute, University of South
Florida
13301 Bruce B. Downs Blvd. MHC 2510
Tampa FL 33612
813-766-3893, fax: 813-974-7376
ndollard@fmhi.usf.edu

Shannon Dorsey, PhD

Assistant Professor
Division of Public Behavioral Health and Justice
Policy, University of Washington School of
Medicine
2815 Eastlake Ave E, Suite 200
Seattle WA 98102
206-685-2085
dorsey2@u.washington.edu

Richard H. Dougherty, PhD

President, Dougherty Management Associates, Inc.
9 Meriam Street, Suite 4
Lexington MA 02420
781-863-8003, fax: 781-863-1519
dickd@dmahealth.com

Karyn L. Dresser, PhD

Director of Research and Program Practices
Stars Behavioral Health Group
7700 Edgewater Drive, Suite 658
Oakland California 94621
510-635-9705 x207
kdresser@starsinc.org

Albert J. Duchnowski, PhD

Professor
Child and Family Studies
University of South Florida
13301 Bruce B. Downs Blvd.
Tampa FL 33612
813-974-4618, fax: 813-974-6257
duchnows@fmhi.usf.edu

Tim Dunst

Chief Executive Officer
Touchstone Behavioral Health
6153 W Olive Ave
Glendale AZ 85302
623-209-1801
timothy.dunst@touchstonebh.org

Chad Ebesutani, MA

Graduate Student
Psychology, UCLA
1285 Franz Hall Box 951563
Los Angeles CA 90024
310.825.2961
ebesutani@ucla.edu

Holly Echo-Hawk, MS

Walter R. McDonald & Associates
16715 Leaper Road
Vancouver WA 98686
360-571-3203, fax: 360-571-3183
echohawk@pacifier.com

Myles Edwards, PhD

Director of Research
Children's Division, American Humane
Association
63 Inverness Drive East
Englewood CO 80112
303-925-9419
mylese@americanhumane.org

Vicki S. Effland, PhD

Director
Outcomes and Evaluation, Choices, Inc.
4701 N. Keystone Ave., #150
Indianapolis IN 46205
317-205-8232, fax: 317-202-4325
veffland@ChoicesTeam.org

Michael Ehling, MS, LCP, LCMFT

Director of Children's Services
Community Mental Health Center of Crawford
County
411 E. Madison
Pittsburg KS 66762
620-232-3228, fax: 620-235-7122
mehling@cmhccc.org

Meredith B. Elzy, MEd

Graduate Assistant
Psychology, Louis de la Parte Florida Mental
Health Institute, University of South Florida
Psychology Department, 4202 East Fowler Ave.,
PCD 4118G
Tampa FL 33620
813-486-6381, fax: 813-228-0360
melzy@mail.usf.edu

Gary Enns, MSW

Children's Care Manager
Thurston-Mason Regional Support Network
412 Lilly Rd NE
Olympia WA 98506
360-786-5836
ENNSG@co.thurston.wa.us

Michael H. Epstein, EdD

William E Barkley Professor
Special Education and Communication Disorders,
University of Nebraska-Lincoln
202 Barkley Memorial Center
Lincoln NE 68583
402-472-5472, fax: 402-472-7697
mepstein@unl.edu

Kenyatta Etchison, PhD

Post Doctoral Fellow
Division of Public Behavioral Health and Justice
Policy, University of Washington School of
Medicine
2815 Eastlake Ave E, Suite 200
Seattle WA 98102
206-685-2085
etchison@u.washington.edu

Mary E. Evans, PhD

Associate Dean for Research & Doctoral Study
College of Nursing, University of South Florida
12901 Bruce B. Downs Blvd.
Tampa FL 33612
813-974-9112, fax: 813-974-5418
mevans@health.usf.edu

Elizabeth M.Z. Farmer, PhD

Associate Professor
Department of Health Policy and Administration,
The Pennsylvania State University
601E Ford Building
University Park PA 16802
814-863-7333
emf13@psu.edu

Jessica Fear, MA, LMFT

FRIENDS Program Director
Community Mental Health Services, Visiting Nurse
Service of New York
489-493 E. 153rd St.
Bronx NY 10455
718-742-7103, fax: 718-401-1321
Jessica.fear@vnsny.org

Bruce Ferguson, PhD

Community Health Resource Group, Hospital for
Sick Children
555 University Avenue
Toronto ON M5G 1X8 Canada
416-813-1085
bruce.ferguson@sickkids.ca

Kathleen Ferreira, MSE

Assistant in Research
Dept. of Child and Family Studies, Louis de la
Parte Florida Mental Health Institute, University of
South Florida
13301 Bruce B. Downs Blvd.
Tampa FL 33612
813-974-5583, fax: 813-974-7563
kferreira@fmhi.usf.edu

John M. Ferrone, MBA, MA

Consultant
Technical Assistance and Consulting, Ferrone
Associates
1126 Country Club Dr
Hastings NE 68901
402-462-0244
jferrone@alltel.net

Sylvia K. Fisher, PhD

Director of Evaluation
Child, Adolescent and Family Branch, Center for
Mental Health Services, Substance Abuse, Mental
Health Services Administration
1 Choke Cherry Road, Room 6-1047
Rockville MD 20857
240-276-1923, fax: 240-276-1930
sylvia.fisher@samhsa.hhs.gov

John Fluke, PhD

Associate Vice President
Center for research on Child Protection, American
Humane Association
63 Inverness Drive East
Englewood CO 80112
303 925 9416
johnf@americanhumane.org

Jeff Folsom, MSW, JD

Chief Operations Officer
A.W.A.R.E. Inc.
616 Helena Ave.
Helena MT 59601
406-449-3120 ext. 14, fax: 406-449-3125
folsom@aware-inc.org

Pennie Foster-Fishman

Professor
Department of Psychology
Senior Outreach Fellow
University Outreach and Engagement
Michigan State University
125 D Psychology Building
East Lansing, MI 48824
517-353-5015, fax: 517-432-2945
fosterfi@msu.edu

Kathleen Fox, PhD

Director of Research
National Indian Child Welfare Association
5100 SW Macadam Ave Suite 300
Portland OR 97239
503-222-4044, fax: 503-222-4007
kfox@nicwa.org

Evelyn Frankford, MSW

Frankford Consulting
40 Williams St
Brookline MA 02446
617-388-0616
efrankford@verizon.net

Robert P. Franks, PhD

Director
Connecticut Center for Effective Practice, Child
Health and Development Institute of Connecticut
270 Farmington Ave., Suite 367
Farmington CT 06032
860-679-1535, fax: 860-679-1521
rfranks@uchc.edu

Karen M. Frensch, MSc

Research Project Manager
Partnerships for Children and Families Project,
Wilfrid Laurier University
120 Duke Street West
Kitchener ON N2H 3W8 Canada
519-884-0710, fax: 519-888-9732
kfrensch@wlu.ca

Travis Fretwell, MAC, NCAC II

Addictive Diseases Program Chief
Department of Human Resources, Division of MH,
DD and AD
2 Peachtree Street N.W., Suite 22-293
Atlanta GA 30303
404-657-2315
tfretwell@dhr.state.ga.us

Robert Friedman, PhD

Professor
Dept. of Child and Family Studies
Louis de la Parte Florida Mental Health Institute
University of South Florida
13301 Bruce B. Downs Blvd.
Tampa FL 33612
813-974-4640, fax: 813-974-6257
friedman@fmhi.usf.edu

Barbara J. Friesen, PhD

Director
Research & Training Center on Family Support and
Children's Mental Health, Portland State University
P.O. Box 751
Portland OR 97207-0751
503-725-4166, fax: 503-725-4180
friesenb@pdx.edu

Mary A. Fristad, PhD, ABPP

Professor
Ohio State University
1670 Upham Drive
Columbus OH 43210
614-293-4572, fax: 614-293-4949
fristad.1@osu.edu

Meghan Gallagher, MSW Candidate

MSW Student
A.W.A.R.E. Inc.
616 Helena Ave.
Helena MT 59601
406-449-3120 ext. 14, fax: 406-449-3125
mgallagher@aware-inc.org

Peter E. Gamache, MBA, MLA, MPH

Child and Family Studies, Louis de la Parte Florida
Mental Health Institute, College of Behavioral and
Community Sciences, University of South Florida
13301 Bruce B. Downs Blvd.
Tampa FL 33612
813-974-8566, fax: 813-974-7376
pgamache@fmhi.usf.edu

Antonio R. Garcia, MSW

Doctoral Student
School of Social Work, University of Washington
4101 15th Ave NE
Seattle WA 98105
206-393-2522
tonyga@u.washington.edu

Janis E. Gerkenmeyer, PhD, MSN, BSN

Associate Professor
School of Nursing, Indiana University
1111 Middle Drive
Indianapolis IN 46202
317-872-6134, fax: 317-247-2411
jgerkens@iupui.edu

Tracy-Ann Gilbert Smith, MS

Social and Behavioral Researcher
Child and Family Studies, Louis de la Parte Florida
Mental Health Institute, University of South
Florida
13301 Bruce B. Downs Blvd.
Tampa, FL 33612
813-974-3341, fax: 813-974-7563
tgsmith@fmhi.usf.edu

John W. Gilford Jr., PhD

Technical Director
Macro International Inc.
3 Corporate Square, Suite 370
Atlanta GA 30329
404-321-3211, fax: 404-321-3688
jwgilford@macrointernational.com

Alissa Gleacher, PhD

Research Scientist
Clinical Psychology and Psychiatry, Columbia
University/NY State Psychiatric Institute
1051 Riverside Dr.
New York NY 10032
212-342-0436, fax: 212-342-0120
GleacheA@childpsych.columbia.edu

Sarah K. Goan, MPP

Evaluator
Hornby Zeller Associates, Inc.
373 Broadway
South Portland ME 04106
207-773-9529, fax: 207-773-9074
sgoan@hornbyzeller.com

Lucas Godoy Garazza, MS

Senior Research Associate
Applied Research, Macro International Inc.
116 John St.
New York NY 10038
646-698-8144
lucas.godoygarazza@macrointernational.com

Geetha Gopalan, LCSW

Pre-Doctoral Intern/Research Coordinator
Department of Psychiatry, Mount Sinai School of
Medicine
1 Gustave Levy Place, Box 1230
New York NY 10029
917-224-2364, fax: 212-851-2386
geetha.gopalan@exchange.mssm.edu

Lucas Godoy Garazza, MS

Senior Research Associate
Applied Research, Macro International Inc.
116 John St.
New York New York 10038
646-698-8144
lucas.godoygarazza@macrointernational.com

Michael Gordon

Professor
Psychiatry, Upstate Medical University
750 East Adams Street
Syracuse NY 13210
315-464-3151
gordonm@upstate.edu

Kris Gowen, PhD

Research Associate
Research & Training Center on Family Support and
Children's Mental Health, Portland State University
P.O. Box 751
Portland OR 97207-0751
503-725-9619, fax: 503-725-4180
gowen@pdx.edu

Virginia Grant

Intensive Reunification Therapist
The Centers
2100 SE 17th Street, Suite 601
Ocala FL 34471
352-867-1536, fax: 352-867-5471
vgrant@thecenters.us

Francine Gravelle

Director
Mental Health Services, Youth Services Bureau of
Ottawa
2675 Queensview Drive
Ottawa ON K2B 8K2 Canada
613-720-0577 x1242, fax: 613-729-1918
fgravelle@ysb.on.ca

Paul Greenbaum, PhD

Research Professor
Child and Family Studies, Louis de la Parte Florida
Mental Health Institute, University of South
Florida
13301 Bruce B. Downs Blvd.
Tampa FL 33612
813-974-4553, fax: 813-974-7563
greenbaum@fmhi.usf.edu

Annette K. Griffith

Assistant Research Professor
Center for At-Risk Children's Services, University of
Nebraska-Lincoln
202 Barkley Memorial Center
Lincoln NE 68583
402-472-6171
agriffith2@unl.edu

Katherine E. Grimes, MD, MPH

Dept. of Psychiatry, Harvard Medical School,
Cambridge Health Alliance
1493 Cambridge St.
Cambridge MA 02139
617-503-8456
Katherine_Grimes@hms.harvard.edu

Chris Groeber, MSW

Consultant
CHES Solutions Group
921 Beasley St. Suite 210
Lexington KY 40509
859-333-7284
chris@chessolutionsgroup.com

Ivor D. Groves, PHD, MAPP

Human Systems and Outcomes Inc
2107 Delta Way
Tallahassee FL 32303
850 524 5683
ivorgroves@mac.com

Kelly Grubbs, MSW, LISW

Director of School-Based Services
Talbert House
4760 Madison Rd
Cincinnati OH 45227
513-321-8286, fax: 513-533-5828
Kelly.Grubbs@talberthouse.org

Phyllis Gyamfi, PhD

Research Scientist
Applied Research Division, Macro International
Inc
3 Corporate Square NE, Suite 370
Atlanta GA 30329
404-321-3211, fax: 404-321-3688
phyllis.gyamfi@macrointernational.com

Brittany Haldeman

Student
Mental Health Law and Policy, University of South
Florida
13301 Bruce B. Downs Blvd.
Tampa FL 33612
813-974-7419, fax: 813-974-6411
baldema@mail.usf.edu

Carol Hardesty, CSW, MPA

Executive Director
Family Ties of Westchester, Inc.
112 East Post Road, 3rd Floor
White Plains NY 10601
914-995-5219, fax: (914) 995-8421
chh2@westchestergov.com

Kathryn Harding, MA

Project Director
Prevent Child Abuse America
500 North Michigan Ave
Chicago IL 60611
312-663-3520, fax: 312-939-8962
harding23@hotmail.com

Robert L. Hartman, MSW, LCPAA

Executive Vice President/COO
DePelchin Children's Center
4950 Memorial Drive
Houston TX 77007
713-802-7774
rhartman@depelchin.org

J. David Hawkins

Professor
Social Development Research Group
University of Washington
9725 3rd Avenue NE
Seattle, WA 98115
206-543-7655, fax: 206-543-4507
jdh@u.washington.edu

Edward M. Hayes

Chief Executive Officer
Cayuga Homes for Children
101 Hamilton Avenue
Auburn NY 13021
315-253-5383
emh1@cayugahome.org

Diane C. Haynes, MA

Statistical Data Analyst
Department of Mental Health Law & Policy,
University of South Florida
13301 Bruce B. Downs Blvd, MHC2621
Tampa FL 33612
813-974-2056, fax: 813-974-6411
dhaynes@fmhi.usf.edu

Craig Anne Heflinger, PhD

Senior Fellow, Institute for Public Policy Studies,
Associate Professor
Human and Organizational Development,
Vanderbilt University
Peabody #90, 230 Appleton Place
Nashville TN 37203
615-322-8275, fax: 615-343-2661
c.heflinger@vanderbilt.edu

Robert Heimbuch, JD

Chief
Juvenile Division, Wayne County Prosecutor's
Office
1025 E. Forest Avenue
Detroit MI 48207
313-833-3105, fax: 313-833-3135
rheimbuc@co.wayne.mi.us

Mario Hernandez, PhD

Professor and Chair
Child and Family Studies,
Louis de la Parte Florida Mental Health Institute,
University of South Florida
13301 Bruce B. Downs Blvd., MHC 2312-A
Tampa FL 33612
813-974-4640, fax: 813-974-7743
hernande@fmhi.usf.edu

Amy D. Herschell, PhD

Assistant Professor of Psychiatry
Western Psychiatric Institute & Clinic, University of
Pittsburgh School of Medicine
3811 O'Hara Street - 537 Bellefield Towers
Pittsburgh PA 15213
412-246-5897
HerschellAD@upmc.edu

Charmaine K. Higa-McMillan, PhD

Faculty
Psychology, University of Hawaii
2430 Campus Road
Honolulu HI 96822
808-733-8354
higac@hawaii.edu

Kimberly E. Hoagwood, PhD

Professor of Clinical Psychology and Psychiatry
Columbia University/NY State Psychiatric Institute
1051 Riverside Dr.
New York NY 10032
212-342-3304, fax: 212-342-0120
hoagwood@childpsych.columbia.edu

Kay Hodges, PhD

Professor
Psychology, Eastern Michigan University
2140 Old Earhart Road
Ann Arbor MI 48105
734-769-9725, fax: 734-769-1434
hodges@provide.net

Sharon Hodges, PhD, MBA

Child and Family Studies
Louis de la Parte Florida Mental Health Institute,
University of South Florida
13301 Bruce B. Downs Blvd.
Tampa FL 33612
813-974-
hodges@fmhi.usf.edu

Michael Hone

Director of Clinical Services
1755 Courtwood Circle
Ottawa ON K2C 3J2 Canada
613-723-1623 x228, fax: 613-723-7393
mhone@crossroadschildren.ca

Bonni D. Hopkins, PhD

Manager of Program Innovation
Public Sector, Magellan Health Services
55 Nod Road
Avon CT 06001
860-673-1212
bdhopkins@magellanhealth.com

Helaine Hornby, MA

Vice President
Hornby Zeller Associates, Inc.
373 Broadway
South Portland ME 04101
207-773-9529, fax: 207-773-9074
hhornby@hornbyzeller.com

Cynthia A. Hovor, MS

Research Associate
NASMHPD Research Institute
66 Canal Center Plaza, Suite 302
Alexandria VA 22314
703-682-7550, fax: 703-548-9517
cynthia.hovor@nri-inc.org

Larke N. Huang, PhD

Senior Advisor on Children
Office of the Administrator, Substance Abuse and
Mental Health Services Administration (SAMHSA)
1 Choke Cherry Rd - Room 8-1051
Rockville MD 20857
240-276-2000, fax: 202-276-2010
Larke.Huang@SAMHSA.hhs.gov

William J. Hudock, MA

Special Expert - Financing Policy
Center for Mental Health Services, Substance
Abuse and Mental Health Services Administration
Rockville MD 20847
240-276-1954, fax: 240-276-1320
William.Hudock@samhsa.hhs.gov

Victoria L. Hummer, MSW

Project Director, Trauma Substudy of Out of Home
Care Grant
Child and Family Studies
Louis de la Parte Florida Mental Health Institute
University of South Florida
13301 Bruce B. Downs Blvd. MHC 2510
Tampa FL 33612
813-766-3893, fax: 813-974-7376
vhummer@fmhi.usf.edu

Pat Hunt

Director of Child and Family Resiliency Services
Magellan Health Services - Public Sector Solutions
P.O. Box 395
Turner ME 04282
207-225-2435
pahunt@magellanhealth.com

Kristin Duppong Hurley

Assistant Research Professor
Center for At-Risk Children's Services, University of
Nebraska-Lincoln
202 Barkley Memorial Center
Lincoln NE 68583
402-472-5501

Sarah Hurley, PhD

Director of Research
Research and Outcome Evaluation, Youth Villages
3320 Brother Blvd
Memphis TN 38133
901-251-4950, fax: 901-251-5018
sarah.hurley@youthvillages.org

David L. Hussey, PhD

Associate Professor
Institute for the Study & Prevention of Violence,
Kent State University
230 Cartwright Hall
Kent OH 44242
330-672-7488
dhussey@kent.edu

Stephanie D. Ingram

Research Analyst
Research Analyst, Boys Town National Research
Institute
14100 Crawford Street
Boys Town NE 68010
402-498-1260
ingrams@boystown.org

Rick Jackson, BA

Administrative Analyst
Behavioral Health, Butte County
109 Parmac, Suite 1
Chico CA 95926
530-879-3342
rjackson@buttecounty.net

William Janes, MA, MA, MMAS

Director, Assistant Secretary
Florida Office of Drug Control, Florida Department
of Children and Families
Florida Office of Drug Control, The Capital, PL04
Tallahassee FL 32399
850-488-9558
William_Janes@eog.MyFlorida.com

Pauline R. Jivanjee, PhD

Research associate
Research and Training Center on Family Support
and Children's Mental Health, Portland State
University
P.O. Box 751
Portland OR 97207
503-725-5015, fax: 503-725-4180
jivanjee@pdx.edu

Rebecca Johansson

Family Member
Manager, Organizational Development, Technip
USA, Harris County Systems of Hope Youth
Services Center
6300 Chimney Rock Road:
Houston TX 77081
713-795-4673, fax: 713-295-2522
samhsa@cps.hctx.ne

Alisha N. Johnson, MPA

Outreach Coordinator
Behavioral Medicine and Clinical Psychology,
Cincinnati Children's Hospital Medical Center
3333 Burnet Avenue, MLC 3015
Cincinnati OH 45229
513-636-1307, fax: 513-636-7400
alisha.johnson@cchmc.org

Carrie L. Johnson, PhD

Director
Seven Generations Child and Family System of
Care, United American Indian Involvement, Inc.
1125 W. 6th Street, Suite 103
Los Angeles CA 90017
213-202-3970, fax: 213-241-0925
drcjohnsn@aol.com

Richard Kamins, PhD

Chief Clinical Officer, Public Sector
Magellan Health Services
7119 S. Glencoe Court
Centennial Colorado 80122
720-529-7427
rikamins@magellanhealth.com

Patrick J. Kanary, MEd

Director
Center for Innovative Practices, Kent University
2890 Hampshire Road
Cleveland Heights OH 44118
216-371-0113, fax: 216-371-0319
pjkanary@sbcglobal.net

Stephen A. Kapp, MSW, PhD

Associate Professor
School of Social Welfare, University of Kansas
1545 Lilac Lane
Lawrence KS 66044
785-864-2269, fax: 785-864-5277
stevek@ku.edu

Courtney Kasinger

Communications Director
Choices, Inc.
4701 N. Keystone Ave., #150
Indianapolis IN 46205
317-205-8268, fax: 317-202-4268
ckasinger@ChoicesTeam.org

Joy S. Kaufman, PhD

Associate Professor
Psychiatry, Yale University School of Medicine
389 Whitney Ave.
New Haven CT 06511
203-789-7645
joy.kaufman@yale.edu

Lara Kaye, PhD

Research Scientist
Center for Human Services Research, University
at Albany
135 Western Avenue
Albany NY 12222
fax: 518-442-5732
lkaye@uamail.albany.edu

Joy S. Kaufman, PhD

Associate Professor
Psychiatry, Yale University School of Medicine
389 Whitney Ave.
New Haven CT 06511
203-789-7645
joy.kaufman@yale.edu

Mansoor A. F. Kazi, PhD

Research Associate Professor and Director
Program Evaluation Center, School of Social Work,
University at Buffalo
State University of New York
671 Baldy Hall
Buffalo NY 14260
716-645-3381, fax: 716-645-3883
mkazi@buffalo.edu

Kevin Keegan, MS

Director of Resource Development, Placement
and Support Service
Social Services Administration, Maryland
Department of Human Resources
311 West Saratoga Street
Baltimore MD 21201
410-767-7910
kkeegan@dhr.state.md.us

Kelly Kelsey, BA

Program Administrator
Department of Psychiatry, Duke University
905 West Main St
Durham NC 27701
919-687-4686, fax: 919-687-4787
kkelsey@psych.duhs.duke.edu

Candy Kennedy, BA

Executive Director
Nebraska Federation of Families
702 West 14th Street
Hastings NE 68901
308-830-0944
ckennedy@nefamilies4kids.org

Joan B. Kernan, BS

Research Associate
Family Medicine, University at Buffalo
462 Grider St. CC-133
Buffalo NY 14215
716-898-4742, fax: 716-898-3536
jkernan@buffalo.edu

Suzanne E. Kerns, PhD

Assistant Professor
Division of Public Behavioral Health and Justice
Policy, University of Washington School of
Medicine
2815 Eastlake Ave E, Suite 200
Seattle WA 98107
206-685-2085
sekerns@u.washington.edu

Ryan P. Kilmer, PhD

Associate Professor
Psychology, The University of North Carolina at
Charlotte
9201 University City Blvd
Charlotte NC 28223
704-687-3689, fax: 704-687-3096
rpkilmer@uncc.edu

Robin J. Kimbrough-Melton, JD

Research Professor
Institute on Family and Neighborhood Life,
Clemson University
158 Poole Agricultural Center
Clemson SC 29634
864-656-6285
rkimbrough@clermson.edu

Ann E. Klein, MA

Director
Outcomes and Evaluation, Hamilton Choices, LLC
644 Linn Street, Suite 900
Cincinnati OH 45203
513-765-5504, fax: 513-765-5555
AKlein@hamiltonchoices.org

Christina Kloker-Young

C.K. Young & Associates
208 Connors Circle
Oak Ridge TN 37830 37830
865-688-0853
ckyoung@bigplanet.com

Nancy Koroloff, PhD

Professor
Research and Training Center on Family Support
and Children's Mental Health, Portland State
University
P.O. Box 751
Portland OR 97207
503-725-9675
koroloff@pdx.edu

Anna Krivelyova, MA

Macro International Inc.
3 Corporate Square, Suite 370
Atlanta GA 30329
404-321-3211, fax: 404-321-3688
anna.krivelyova@macrointernational.com

Krista Kutash, PhD

Professor
Child and Family Studies, Louis de la Parte Florida
Mental Health Institute, University of South
Florida
13301 Bruce B Downs Blvd
Tampa FL 33612
813-974-4622
kutash@fmhi.usf.edu

Christa Labouliere, MA

Psychology, University of South Florida
4202 E. Fowler Avenue, PCD 4118G
Tampa FL 33620
774-240-9383
clabouli@cas.usf.edu

Jason A. Lang, PhD

Program Associate
Connecticut Center for Effective Practice
270 Farmington Ave., Suite 367
Farmington, CT 06032
860-679-1550, fax: 860-679-1521
jalang@uchc.edu

Ranilo Laygo, PhD

Assistant Professor
University of Hawaii, Manoa, Project Ho'omohala
1776 University Avenue, UA4-6
Honolulu HI 96822
808-956-0775, fax: 808-956-3162
ranilo@hawaii.edu

Katherine J. Lazear, MA

Social and Behavioral Researcher
Child and Family Studies, Research and Training
Center for Children's Mental Health, Louis de la
Parte Florida Mental Health Institute, University of
South Florida
13301 Bruce B. Downs Blvd.
Tampa FL 33612
202-337-2412, fax: 202-333-8217
lazear@fmhi.usf.edu

Bethany Lee, PhD

Assistant Professor
Social Work, University of Maryland, Baltimore
525 W. Redwood St.
Baltimore MD 21201
410-706-3809
blee@ssw.umaryland.edu

Jody Levison-Johnson, LCSW

Director
Child & Family Service Quality & System
Development, Coordinated Care Services, Inc./
Monroe County Office of Mental Health
1099 Jay Street, Building J
Rochester NY 14611
585-613-7648, fax: 585-328-5211
jlevison-johnson@ccsi.org

Cathleen A. Lewandowski, PhD

Associate Professor and Director
School of Social Welfare, University at Albany
135 Western Avenue
Albany NY 12222
518-591-8784, fax: 518-442-5732
clewandowski@uamail.albany.edu

Ladel Lewis, MA

Evaluation Coordinator
Sociology, Kalamazoo Wraps
1908 W. Michigan
Kalamazoo MI 49008
269-387-3600
ladel.lewis@wmich.edu

Carolyn Lichtenstein, PhD

Walter R. McDonald & Associates
12300 Twinbrook Parkway, Suite 310
Rockville MD 20852
301-881-2590, fax: 301-881-0096
clichtenstein@wrma.com

Robert E. Lieberman, MA, LPC

Southern Oregon Adolescent Study and Treatment
Center
715 Ramsey Avenue
Grants Pass OR 97527
(541) 956-4943 x1117, fax: (541) 476-5463
rlieberman@soastc.org

Brian Lombrowski

CAFETY
2nd floor, 277 Starr St.
Brooklyn, NY 11237
brian.lombrowski@gmail.com

Ira Lourie, M.D.

Senior Medical Consultant
A.W.A.R.E. Inc.
616 Helena Ave.
Helena MT 59601
406-449-3120 ext. 14
mgallagher@aware-inc.org

Laurel M. Lunn, MEd

PhD Student; Community Research & Action
Human and Organizational Development, Vanderbilt
University
Peabody #90; 230 Appleton Pl
Nashville TN 37203
703-408-0751
laurel.m.lunn@vanderbilt.edu

David Lindy, Ph. D.

Visiting Nurse Service of New York
New York, NY

Anna M. Malsch, PhD

Research Associate
Research and Training Center on Family Support and
Children's Mental Health, Portland State University
P.O. Box 751
Portland OR 97207
503-725-8767, fax: 503-725-4180
amalsch@pdx.edu

Connie Maples, MS

Research Associate
Macro International
3 Corporate Square NE, Suite 370
Atlanta GA 30329
404-321-3211, fax: 404-321-3688
Connie.J.Maples@macrointernational.com

Luther C. Marcena, PhD

Communications, Training, and Technical Assistance
Coordinator
Border Children's Mental Health Collaborative
El Paso County - BCMHC
119 Stanton, 9th Floor
El Paso TX 79001
915-351-1288
lmarcena@epcounty.com

Maureen Marcenko, PhD

Associate Professor
School of Social Work, University of Washington
4101 15th Ave NE
Seattle WA 98105
206-543-3546
mmarcenk@u.washington.edu

Jan M. Markiewicz, PhD

Director, Training and Implementation
Duke National Center for Traumatic Stress, UCLA
905 W. Main St. Ste 24-E
Durham NC 27701
919-682-1552 ext 261, fax: 919-667-2350
jmarkiewicz@psych.duhs.duke.edu

Ken Martinez, PsyD.

Mental Health Resource Specialist
Technical Assistance Partnership for Children and
Families' Mental Health, American Institutes for
Research
1000 Thomas Jefferson Street
Washington DC 20007
505-980-2220, fax: (505) 980-5837
kmartinez@air.org

Jessica Mass-Levitt, PhD

Research Scientist
Clinical Psychology and Psychiatry, Columbia
University/NY State Psychiatric Institute
1051 Riverside Dr.
New York NY 10032
LevittJ@childpsych.columbia.edu

Cori Mathew, MHR

Director of Youth Services
Youth Services, Native American Youth & Family
Center
5135 NE Columbia Blvd
Portland OR 97218
503-288-8177
corim@nayapdx.org

Samantha L. Matlin, PhD

Postdoctoral Fellow
Connecticut Center for Effective Practice
270 Farmington Ave., Suite 367
Farmington, CT 06032
860-679-1524, fax: 860-679-1521
samantha.matlin@yale.edu

John B. Mayo, MA

Deputy Executive Director
Success 4 Kids & Families, Inc.
1311 N. Westshore Blvd., Suite 302
Tampa FL 33607
813-490-5490, fax: 813-490-5495
jmayo@s4kf.org

Karen Maziarz

Sr. Vice President
Hillsborough Kids, Inc.
9309 N. Florida Avenue, Suite 107
Tampa FL 33612
813-225-1105 x105, fax: 813-226-0661
Karen.Maziarz@HillsboroughKids.org

Vicki L. McCarthy

Director
Families CAN
135 Delaware Avenue, Suite 210
Buffalo NY 14202
716-884-2599
vicky@compeerbuffalo.org

Diana McIntosh, PhD

Vice President, Clinical Services
Hamilton County Mental Health and Recovery
Services Board
2350 Auburn Ave
Cincinnati OH 45219
513-946-8603, fax: 513-946-8610
dianam@hamilton.mhhsb.state.oh.us

Janet S. McIntyre, MPA

Director
Choices TA Center, Choices, Inc.
4701 N. Keystone Ave., #150
Indianapolis IN 46205
317-205-8266, fax: 317-202-4248
jmcintyre@choiceteam.org

Mary M. McKay, PhD, LCSW

Professor
Department of Medicine and Community
Psychiatry, Mount Sinai School of Medicine
1 Gustave L Levy Place
New York NY 10029
212-659-8836
mary.mckay@mssm.edu

Curtis McMillen, PhD

Professor
George Warren Brown School of Social Work,
Washington University
One Brookings Drive, Campus Box 1196
St. Louis MO 63130
cmcmlle@wustl.edu

Larkin S. McReynolds, PhD

Research Director
Center for the Promotion of Mental Health in
Juvenile Justice, Columbia University/NYSPI
1051 Riverside Drive (unit 78)
New York NY 10032
212-543-5158, fax: 212-543-1000
mcreynol@childpsych.columbia.edu

Gary B. Melton, PhD

Professor & Director
Institute on Family and Neighborhood Life,
Clemson University
158 Poole Agricultural Center
Clemson SC 29634
864 656 6271
gmelton@clemson.edu

Jennifer E. Mettrick, MHS

Research Supervisor
Psychiatry/Division of Child & Adolescent
Psychiatry, University of Maryland School of
Medicine
737 W. Lombard Street, 4th Floor
Baltimore MD 21201
410-706-4712, fax: 410-706-6220
jmettrick@psych.umaryland.edu

Joan Mikula

Assistant Commissioner, Child and Adolescent
Services
MA Department of Mental Health
25 Staniford St
Boston MA 02114
617-626-8026
joan.mikula@state.ma.us

Heidi A. Milch, LMSW

Executive Director
Community Connections of New York
605 Niagara Street
Buffalo NY 14201
716-883-4531, fax: 716-829-1549
hmlch@comconnectionsny.org

Matt M. Miller

Vice President, Network
Public Sector Solutions, Magellan Health Services
105 Terry Drive, Suite 103
Newtown PA 18940
267-496-7408
mmmiller@magellanhealth.com

Monica Mitchell, PhD

Assistant Professor
Division of Behavioral Medicine and Clinical
Psychology, Cincinnati Children's Hospital Medical
Center
3333 Burnet Avenue
Cincinnati OH 45229
513-636-3375, fax: 513-636-7400
monica.mitchell@cchmc.org

Angela Montanago, PhD

Senior Research Associate
Macro International, Inc.
3 Corporate Square, N.E.
Atlanta GA 30329
404-321-3211
Angela.Montanago@macrointernational.com

Kurt Moore, PhD, LPC

Walter R. McDonald and Associates, Inc.
999 18th St. suite 2700
Denver CO 80202
303-357-4678, fax: 303-357-4679
kmoore@wrma.com

Patricia S. Motes, PhD

Research Professor
Institute on Family and Neighborhood Life,
Clemson University
158 Poole Agricultural Center
Clemson SC 29634
864-430-1623
pmotes@clemson.edu

Charles W. Mueller, PhD

Professor of Social and Clinical Psychology
Psychology, University of Hawaii
2500 Campus Road
Honolulu Hawaii 96822
808-944-7760
cmueller@hawaii.edu

Michelle R. Munson, PhD

Assistant Professor
Mandel School of Applied Social Sciences, Case
Western Reserve University
10900 Euclid Avenue
Cleveland OH 44106
216-368-5878
michelle.munson@case.edu

Maureen Murray, MSW, LCSW

Assistant Professor
Department of Psychiatry, Duke University
905 West Main St
Durham NC 27701
919-687-4686, fax: 919-687-4787
murra024@mc.duke.edu

Fran Myers-Routt, MSW

Director of Clinical Services
Manatee Palms Youth Services
4480 51st Street West
Bradenton FL 34210
941-792-2222, fax: 941-761-1632
fran.routt@psysolutions.org

Rick Nance, LCSW, CADC

Administrator
Division of Alcoholism and Substance Abuse,
Office of Program Administration, Illinois
Department of Human Services
319 East Madison, Suite 2d
Springfield IL 62701
217-557-6706
RICK.NANCE@illinois.gov

Sarah Narendorf, LCSW

Doctoral Student, NIMH Predoctoral Fellow
George Warren Brown School of Social Work,
Washington University
One Brookings Drive, Campus Box 1196
St. Louis MO 63130
snarendorf@gwbmail.wustl.edu

Teresa Nesman, PhD

Research Assistant Professor
Child & Family Studies, FLORIDA MENTAL HEALTH
INSTITUTE/University of South Florida
13301 Bruce B. Downs Blvd.
Tampa FL 33612
813-974-4651, fax: 813-974-7563
nesman@fmhi.usf.edu

Trina E. Orimoto, CA

Graduate Student
Psychology, University of Hawaii
2430 Campus Road
Honolulu HI 96822
808-295-4167
torimoto@gmail.com

Ukamaka M. Oruche, MSN

PhD Student
School of Nursing, Indiana University
1111 Middle Drive
Indianapolis IN 46202
317-418-5355, fax: 317-274-2411
uoruche@iupui.edu

Trina W. Osher, MA

Co-chair Family Partner Task Force
National Wraparound Initiative, Huff Osher
Consulting, Inc.
8025 Glenside Drive
Takoma Park MD 20912
301-434-4071
tosher3@comcast.net

Brian M. Pagkos, LMSW, ABD

Evaluator
Community Connections of New York
605 Niagara Street
Buffalo NY 14201
716-430-3304, fax: 716-829-1549
bpagkos@comconnectionsny.org

Jung Min Park, PhD

Assistant Professor
School of Social Work, University of Illinois at
Urbana-Champaign
1207 W. Oregon St.
Urbana IL 61801
217-244-5243
parkjm@illinois.edu

Thomas W. Pavkov, PhD

Director
Institute for Social and Policy Research, Purdue
University Calumet
2200 169th Street
Hammond IN 46323
219-670-2489, fax: 219-989-3161
tpavkov@calumet.purdue.edu

Malisa Pearson

ACMH Conference Coordinator
Association for Children's Mental Health
2465 Woodlake Circle, Suite 140
Okemos MI 48864
517-381-5125, fax: 517-349-6329
Acmhmalisa@aol.com

Peter J. Pecora, PhD

Senior Director of Research Services
Casey Family Programs
1300 Dexter Avenue North, Floor Three
Seattle WA 98109
206-270-4936, fax: 866-322-7863
Ppecora@casey.org

Marlene Penn

Co-chair Family Partner Task Force
National Wraparound Initiative
8 Tudor Court
Medford NJ 08055
609-654-1443
mpenn8@aol.com

Ramona G. Perry

Undergraduate NIMH-funded Project L/Earn
intern
Institute for Health, Health Care Policy, and Aging
Research, Rutgers University
30 College Avenue
New Brunswick NJ 08901
732-552-6417, fax: 732-932-8181
rperry@ifh.rutgers.edu

Neil Pessin, PhD

Director, Community Mental Health Services
Community Mental Health Services, Visiting Nurse
Service of New York
1250 Broadway, 22nd Floor
New York NY 10001
212-609-7770, fax: 212-290-3532
Npessin@vnsny.org

Beth Piecora, BS

Family Advocate and Organizational Consultant
Success 4 Kids & Families, Inc.
1311 N. Westshore Blvd., Suite 302
Tampa FL 33607
813-490-5494, fax: 813-490-5495
bpiecora@tampabay.rr.com

Sandra Pimentel, PhD

Child Psychiatry, Columbia University/NY State
Psychiatric Institute
1051 Riverside Dr.
New York NY 10032
PimenteS@childpsych.columbia.edu

Allison Pinto, PhD

Complexity Scientist-Practitioner
Research and Evaluation, Children's Board of
Hillsborough County
1002 E Palm Ave
Tampa FL 33605
813-204-1730
apinto@childrensboard.org

Sheila A. Pires, M.P.A.

Partner, Human Service Collaborative
1728 Wisconsin Avenue, NW, #224
Washington DC 20007
202-333-1892, fax: 202-333-8217
SAPires@aol.com

Keith R. Pirtle, MSW

State Project Director
Oklahoma Systems of Care, Oklahoma
Department of Mental Health & Substance Abuse
Services
1200 NE 13th Street, PO Box 53277
Oklahoma City OK 73152
405-522-6770, fax: 405-522-3650
kpirtle@odmhsas.org

Robert Plant, PhD

Director of Behavioral Health Programs and
Services
Bureau of Behavioral Health, Connecticut
Department of Children and Families
505 Hudson St.
Hartford CT 06106
860-560-5035
Robert.Plant@po.state.ct.us

Kathleen C. Plum, RN, PhD

Director
Monroe County Office of Mental Health, Monroe
County Department of Human Services
1099 Jay Street, Building J
Rochester NY 14611
585-753-6047, fax: 585-753-6620
kplum@monroecounty.gov

Jeffrey M. Poirier, MA

Senior Research Analyst
American Institutes for Research
1000 Thomas Jefferson St., NW
Washington DC 20007
202-403-5368
jpoirier@air.org

Kathleen J. Pottick, PhD

Professor
Institute for Health, Health Care Policy and Aging
Research, Rutgers University
30 College Avenue
New Brunswick NJ 08901
732-932-6872, fax: 732-932-8181
pottick@rci.rutgers.edu

Jane Powers

Vice President
Public Sector Consultants Inc.
600 W. Saint Joseph St. Suite 10
Lansing MI 48933-2267
517-484-4954
jpowers@pscinc.com

Ron V. Prator, PhD

Clinical Coordinator
RESOLVE Behavioral Health services, Colonial
Intermediate Unit 20
6 Danforth Drive
Easton PA 18045-7899
610-515-6473, fax: 610-559-7103
rprator@ciu20.org

Deborah Purce, JD

Executive Staff Director
Children's Administration, Washington State
Department of Social and Health
Olympia WA 98504
purcelaw@sbcglobal.net

Vashti Pussman, MSW

Care Management Supervisor
Border Children's Mental Health Collaborative, El Paso
County - BCMHC
119 Stanton, 9th Floor
El Paso TX 79001
915-351-1288
vpussman@epprovidergroup.org

Marleen S. Radigan, DrPH, MPH, MS

Associate Director, Bureau of Youth Services Research
Center for Information Technology and Evaluation
Research, New York State Office of Mental Health
44 Holland Avenue
Albany NY
518-473-9570
coevmsr@omh.state.ny.us

Irene K. Rickus, MS, LMHC

Chief Operations Officer
Operations, Kids Central, Inc.
2117 SW Highway 484
Ocala FL 34473
352-873-6332, fax: 352-291-8658
irene.rickus@kidscentralinc.org

Kara S. Riehman, PhD

Technical Director
Macro International Inc.
3 Corporate Square NE, Suite 370
Atlanta GA 30329
404-592-2148, fax: 404-321-3688
kara.s.riehman@macrointernational.com

Jeanne C. Rivard, PhD

Director of Special Studies
NASMHPD Research Institute
66 Canal Center Plaza, Suite 302
Alexandria VA 22314
703-682-9468, fax: 703-548-9517
jeanne.rivard@nri-inc.org

Mary Lee Robbins, MA, MSW, LCSW

Project Manager
School of Social Welfare, University of Kansas
1545 Lilac Lane
Lawrence KS 66044
785-865-4386, fax: 785-830-8026
robbins@ku.edu

Rebecca S. Robbins, BS

Project Manager
ASO, Children's Board of Hillsborough County
1002 E. Palm Avenue
Tampa FL 33605
813-204-1749, fax: 813-229-1941
rrobbins@childrensboard.org

John Robst, PhD

Research Associate Professor
Department of Mental Health Law & Policy, Louis de
la Parte Florida Mental Health Institute, University of
South Florida
13301 Bruce B. Downs Blvd.
Tampa FL 33612
813-974-1505
jrobst@fmhi.usf.edu

James Rodriguez, PhD

Research Scientist
Clinical Psychology and Psychiatry, Columbia
University/NY State Psychiatric Institute
1051 Riverside Dr.
New York NY 10032
212-342-0590, fax: 212-342-0120
RodriguJa@childpsych.columbia.edu

Stephen Roggenbaum, MA

Assistant in Research
Department of Child and Family Studies
Florida Mental Health Institute
University of South Florida
13301 Bruce B Downs Blvd
Tampa FL 33612
813-974-6149, fax: 813-974-7376
roggenbaum@fmhi.usf.edu

Lisa Hunter Romanelli, MD

President & CEO
The REACH Institute
450 7th Avenue, Suite 1107
New York NY 10123
212-947-7322 x224
lisa@thereachinstitute.org

Knute I. Rotto, ACSW

CEO
Choices, Inc.
4701 N. Keystone Ave., #150
Indianapolis IN 46205
317-205-8202, fax: 317-202-4202
krotto@ChoicesTeam.org

David Saarnio

Psychology & Counseling, Arkansas State
University
PO Box 1560
State University AR 72467
870-972-3064, fax: 870-972-3962
dsaarnio@astate.edu

April Sather

Research Coordinator
Dept. of Psychiatry & Behavioral Sciences,
University of Washington
Seattle Washington 98103
206-685-2310
sathea@u.washington.edu

**Lindsay F. Satterwhite, M.A Counselor
Education**

Doctoral Student, Community Research & Action
Human and Organizational Development,
Vanderbilt University
2025 Woodmont Blvd., Apt. 215
Nashville TN 37215
859-421-8011
lindsay.f.satterwhite@vanderbilt.edu

Sheryl Schrepf

Sarasota FL
402-770-2980
saschrepf@aol.com

Jennifer A. Schroeder, PhD

Program Associate for Mental Health
Connecticut Center for Effective Practice, Child
Health and Development Institute of Connecticut
270 Farmington Ave., Suite 367
Farmington CT 06032
860 679-1535, fax: 860 679-1521
jschroeder@uchc.edu

Harriet Scott

Director
Positive Support for Parents in Neighborhoods
(+SPIN)
5118 N. 56th Street, Suite 242
Tampa FL 33610
(813) 977-7677, fax: 813-977-5017
hscott@positivespinfl.org

Jennifer A. Schroeder, PhD

Program Associate
Connecticut Center for Effective Practice
270 Farmington Ave., Suite 367
Farmington, CT 06032
860-679-1535, Fax: 860-679-1521
jschroeder@uchc.edu

Charles H. Seagle, PhD

Senior Research Associate
Macro International, Inc.
116 John Street, Suite 800
New York NY 10038
646-695-8120, fax: 212-941-7031
charles.h.seagle@macrointernational.com

Ashli Sheidow, PhD

Research Associate Professor
Family Services Research Center, Dept. of
Psychiatry, Medical University of South Carolina
67 President Street, Suite CPP
Charleston SC 29425
843-876-1838, fax: 843-876-1808
sheidoaj@muscc.edu

Charles H. Seagle, PhD

Senior Research Associate
Macro International, Inc.
116 John Street, Suite 800
NEW YORK NY 10038
646-695-8120, fax: 212-941-7031
charles.h.seagle@macrointernational.com

Dorindia Sheppard

Black Family Development, Inc.
2995 East Grand Boulevard
Detroit MI 48202
313-420-9016

Matt Sheridan, MSW

Supervisor, Family Services
Kinark Child and Family Services
380 Armour Road, Suite 275
Peterborough ON K9H 7L7 Canada
705-742-3803
matt.sheridan@kinark.on.ca

Susan Smalling, MSW

Doctoral Fellow
Mandel School of Applied Social Sciences, Case
Western Reserve University
10900 Euclid Avenue
Cleveland OH 44106
susan.smalling@case.edu

Christopher L. Smith, PhD

Assistant Research Professor
Life Span Institute, University of Kansas
2601 Gabriel
Parsons KS 67357
620-421-6550, fax: 620-421-0671
clsphd@ku.edu

Corvette Smith

Foster Parent Advocate
Harlem Dowling – West Side Center
2971 8th Avenue, Apt 13N
New York NY 10039
646-303-8165

Cynthia Smith, MSW

Chief Executive Officer
Juvenile Assessment Center
7310 Woodward Avenue
Detroit MI 48202
313-896-1444, fax: 313-896-1466
csmith@assuredfamilyservices.org

Dannia G. Southerland, MSW, PhD

Department of Psychiatry, Duke University
905 West Main St
Durham NC 27701
919-687-4686, fax: 919-687-4787
dannia.southerland@duke.edu

Amy C. Starin, PhD

Associate Deputy Clinical Director
Child & Adolescent Services, Illinois Division of
Mental Health
4200 N. Oak Park Ave.
Chicago IL 60304
773-794-4850, fax: 773-794-4881
amy.starin@illinois.gov

Dannia G. Southerland, MSW, PhD

Department of Psychiatry, Duke University
905 West Main St
Durham NC 27701
919-687-4686, fax: 919-687-4787
dannia.southerland@duke.edu

Adam G. Stein, PhD

Senior Consultant
The Early Childhood Center, Albert Einstein
College of Medicine
One Bridge Street, Suite 24
Irvington NY 10533
914-730-9280, fax: 914-591-4225
astein@rivertownsattention.com

Linda S. Stephan, DNS, MSN

Director of Ambulatory Behavioral Care Services
Nursing, Community Health Network
7150 Clearvista Drive
Indianapolis IN 46256
317-621-2952
lsstephan@ecomunity.com

Sharon Stephan, PhD

Assistant Professor
Psychiatry/Division of Child & Adolescent
Psychiatry, University of Maryland School of
Medicine
737 West Lombard Street, 4th Floor
Baltimore MD 21201
410-706-0941, fax: 410-706-6220
sstephan@psych.umaryland.edu

Erin Stettler, MPH

Data and Program Evaluation Manager
The Early Childhood Center, Albert Einstein
College of Medicine
1731 Seminole Avenue
Bronx NY 10461
718-430-4100, fax: 718-892-4736
estettler@aecom.edu

Karen Stipp, MSW

Graduate Research Assistant
School of Social Welfare, University of Kansas
1545 Lilac Lane
Lawrence KS 66045
785-864-8972, fax: 785-864-5277
ksudu@ku.edu

Kelly Stone, MS

Project Supervisor
Trauma Recovery Initiative, Children's Home
Society of FL Western Division
1300 N. Palafox St. Suite 103
Pensacola FL 32501
850-266-2700, fax: 850-595-0180
Kelly.stone@chsfll.org

Beth Stroul, MEd

President
Management & Training Innovations, Inc.
7417 Seneca Ridge Drive, Suite 100
McLean VA 22102
703-448-7570, fax: 703-448-7571
bethstroul@aol.com

Bhuvana Sukumar, MSW, PhD

Project Manager
Applied Research Division, Macro International
3, Corporate Square
Atlanta Ga 30329
404-321-3211
bhuvana.sukumar@macrointernational.com

Carolyn Sullins, PhD

Lead Evaluator for Kalamazoo Wraps
The Kercher Center for Social Research
Western Michigan University
Kalamazoo MI 49008
269-387-3599, fax: 269-387-2882
carolyn.sullins@wmich.edu

Christopher Sullivan, PhD

Assistant Professor
Department of Criminology, University of South
Florida
4202 E Fowler Ave
FL 33620
813-974-2251
csullivan@cas.usf.edu

W. Carl Sumi, PhD

Senior Research Analyst
Center for Education and Human Services, SRI
International
333 Ravenswood Ave
Menlo Park CA 94025
650-859-5135, fax: 650-859-3092
carl.sumi@sri.com

Jesse C. Suter, PhD

Research Assistant Professor
Center on Disability and Community Inclusion,
University of Vermont
311 Mann Hall, 208 Colchester Ave
Burlington VT 05405-1757
802-656-1130, fax: 802-656-1357
jesse.suter@uvm.edu

W. Carl Sumi, PhD

Senior Research Analyst
Center for Education and Human Services, SRI
International
333 Ravenswood Ave
Menlo Park CA 94025
650-859-5135, fax: 650-859-3092
carl.sumi@sri.com

Natasha Talartcheff-Quesnel

Manager
Ottawa Children's Coordinated Access and
Referral to Services
2675 Queensview Drive
Ottawa ON K2B 8K2 Canada
613-720-0577 x1256, fax: 613-288-0426
natasha@coordinatedaccess.ca

Michael O. Taylor, MSW, PhD

Assistant Professor
Child and Family Studies - School of Social Work,
Portland State University
PO Box 751 - CFS
Portland OR 97207
503-725-8589, fax: 503-725-5323
motaylor@pdx.edu

Sarah Taylor, MSW

Post-Doctoral Fellow and Associate Research
Scientist
Prevention Research Center
1995 University Avenue, Suite 450
Berkeley California 94704
510-883-5778
staylor@prev.org

Rahel Tekle, MS

Manager
Outcomes and Evaluation, Maryland Choices
5 Choke Cherry Rd., Suite 280
Rockville MD 20850
240-683-7307, fax: 301-947-0199
rtekle@mdchoices.org

Wes Temple, BS

Project Manager
Positive Behavior Support, Education Service
Center - Region 19
6611 Boeving Drive
El Paso TX 79925
915-780-1919, fax: 915-780-6537
lmarcena@epcounty.com

Ronald W. Thompson, PhD

Director
National Research Institute for Child and Family
Studies, Boys Town
14100 Crawford St.
Boys Town NE 68010
402-498-1254, fax: 402-498-1315
thompsonr@boystown.org

Ryan T. Tolman, MA

Graduate Student
Psychology, University of Hawaii
2430 Campus Road
Honolulu HI 96922
808-733-8384
rtolman@hawaii.edu

Leah W. Travis, MS

Research Associate
Institute for Social and Policy Research, Purdue
University Calumet
2200 169th Street
Hammond IN 46323
219-670-2489, fax: 219-989-3161
tpavkov@calumet.purdue.edu

Eric W. Trupin, PhD

Professor and Director
Division of Public Behavioral Health and Justice
Policy, University of Washington School of
Medicine
2815 Eastlake Ave E, Suite 200
Seattle WA 98102
206-685-2085, fax: 206-685-3430
trupin@u.washington.edu

Emilio Vaca

Facilitator
Creciendo Unidos/Creating Alternatives
P.O. Box 1053
Kings Beach CA 96143
530-386-6253
emiliovaca@hotmail.com

Jessica Valenzuela, PhD

Fellow
Behavioral Medicine and Clinical Psychology,
Cincinnati Children's Hospital Medical Center
3333 Burnet Avenue, MLC 3015
Cincinnati OH 45229
513-636-7733, fax: 513-636-7400
jessica.valenzuela@cchmc.org

Shannon R. Van Deman, MBA

Financial Risk Manager
Choices, Inc.
4701 N. Keystone Ave., #150
Indianapolis IN 46205
317-205-8311, fax: 317-202-4308
svandeman@ChoicesTeam.org

Jeffrey J. Vanderploeg, PhD

Program Associate
Connecticut Center for Effective Practice
270 Farmington Ave., Suite 367
Farmington, CT 06032
860-679-1542, fax: 860-679-1521
jeffrey.vanderploeg@yale.edu

Shannon R. Van Deman, MBA

Financial Risk Manager
Choices, Inc.
4701 N. Keystone Ave., #150
Indianapolis IN 46205
317-205-8311, fax: 317-202-4308
svandeman@ChoicesTeam.org

Keren S. Vergon, PhD

Assistant Professor
Child and Family Studies, Louis de la Parte Florida
Mental Health Institute/College of Behavioral &
Community Sciences/University of South Florida
13301 Bruce B. Downs Blvd.
Tampa FL 33612
813-974-8949, fax: 813-974-0939
vergon@fmhi.usf.edu

Mary Wagner, PhD

Co-Director
Center for Education and Human Services, SRI
International
333 Ravenswood Ave
Menlo Park CA 94025
650-859-2867, fax: 650-859-3092
mary.wagner@sri.com

Christine M. Walrath, MHS, PhD

Vice President
Macro International Inc.
116 John Street, Suite 800
New York, NY 10038
646-695-8154, fax: 212-941-7031
Christine.M.Walrath-Greene@macrointernational.com

Abe Wandersman

Professor
Department of Psychology
Barnwell College, Room 543
University of South Carolina
Columbia, South Carolina 29208
807-777-7671, fax: 803-777-9558
wandersman@sc.edu

Rui Wang, MS

Research Scientist
Office of Performance Measurement and
Evaluation, Office of Mental Health
New York State
44 Holland Ave
Albany NY 12229
518-474-0717
coevrwww@omh.state.ny.us

Gail A. Wasserman, PhD

Professor of Clinical Psychology
Child Psychiatry, Columbia University/NYSPI
1051 Riverside Drive (Unit 78)
New York NY 10032
212-543-5296, fax: 212-543-1000
wassermg@childpsych.columbia.edu

Kathryn C. Wehrmann, PhD

Associate Professor
Social Work, Illinois State University
Campus Box 4650
Normal IL 61790-4650
309-438-5903, fax: 309-438-5880
kcwehrm@ilstu.edu

Josie A. Welsh, PhD

Evaluation Specialist
Office of Behavioral Research and Evaluation,
Arkansas State University
P.O. Box 1560
State University AR 72467
870-972-2287
jwelsh@astate.edu

Laura Whalen, MPH

Senior Research Associate
Macro International Inc.
3 Corporate Square NE Suite 370
Atlanta GA 30329
404-321-3211
laura.whelen@macrointernational.com

Melissa L. Whitson, PhD

Postdoctoral Fellow
Department of Psychiatry, Yale University School
of Medicine
389 Whitney Ave.
New Haven CT 06511
203-789-7645
melissa.whitson@yale.edu

Craig Wiles, MS

Consultant for Evaluation and Survey Research
Public Sector Consultants Inc.
600 W. Saint Joseph St. Suite 10
Lansing MI 48933-2267
517-484-4954
cwiles@pscinc.com

Melissa L. Whitson, PhD

Postdoctoral Fellow
Psychiatry, Yale University School of Medicine
389 Whitney Ave.
New Haven CT 06511
203-789-7645
melissa.whitson@yale.edu

Cynthia Williams

Program Manager
Black Family Development, Inc.
2995 E. Grand Boulevard
Detroit MI 48202
313-758-0150, fax: 313-758-0280
kstephens@blackfamilydevelopment.org

Stephen Williams, MS

Governing Board Chair
Director Health and Human Services Commission,
City of Houston, Systems of Hope
6300 Chimney Rock Road
Houston TX 77081
713-795-4673, fax: 713-295-2522
samhsa@cps.hctx.net

Amy J. Winans

Executive Director
Association for Children's Mental Health
2465 Woodlake Circle, Suite 140
Okemos MI 48864
517-381-5125, fax: 517-349-6329
ajwinans@aol.com

Matt Wojack, MSW

Project Director
Impact, Ingham County System of Care Initiative,
Community Mental Health Board of Clinton,
Eaton and Ingham Counties
5303 S. Cedar St., Bldg. 2
Lansing MI 48911
517-346-8038
wojack@ceicmh.org

Ginny Wood

President
Family Support Systems, Inc.
20487 North 94th Avenue
Peoria AZ 85382
623-825-1744, fax: 623-825-7130
Ginnywood@cox.net

Michelle Woodbridge, PhD

Senior Research Analyst
Center for Education and Human Services, SRI
International
333 Ravenswood Ave
Menlo Park CA 94025
650-859-6923, fax: 650-859-3092
michelle.woodbridge@sri.com

James R. Wotring, MSW

Director
National Technical Assistance Center for Children's
Mental Health, Georgetown University Center for
Child And Human Development
3300 Whitehaven Street, NW, Suite 3300
Washington DC 20007
202-687-5052, fax: 202-687-1954
jrw59@georgetown.edu

Jim Wotring, MSW

Director
National Technical Assistance Centre for Children's
Mental Health, Georgetown University
3330 Whitehaven Street NW, Suite 3300
Washington DC 20007
202-687-5052
jrw59@georgetown.edu

Svetlana Yampolskaya, PhD

Research Assistant Professor
Child and Family Studies
Louis de la Parte Florida Mental Health Institute
University of South Florida
13301 Bruce B. Downs Blvd.
Tampa FL 33612
813-974-8218, fax: 813-974-7563
yampol@fmhi.usf.edu

Joan Yengo

Program Manager
Mary's Center for Maternal and Child Health,
Healthy Families DC
2333 NW Ontario Road
Washington DC 20009
(202) 483-8319, fax: (202) 797-2628
jyengo@maryscenter.org

Eileen Youmans

Intensive Reunification Case Manager
Camelot Community Care
1601 NE 25th Avenue, Suite 702
Ocala FL 34478
352-843-5044, fax: 352-754-1101
eileen.youmans@kidscentralinc.org

Peter Zucker, PhD

Vice President
Clinical Services, Stars Behavior Health Group
1501 Hughes Way, Suite 150
Long Beach California 90810
301-221-6336
pzucker@stasrsinc.com

Author Index

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Miller, Matt M. 33	Poirier, Jeffrey M. 42	Stein, Adam G. 115	Welsh, Josie A. 211
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Pecora, Peter J. 43, 115	Scott, Harriet 214	Valenzuela, Jessica 133	
Penn, Marlene 54, 89, 230	Seagle, Charles H. 105, 106	Van Deman, Shannon R. 48, 50	
Perry, Ramona G. 135	Sheidow, Ashli 55	Vanderploeg, Jeffrey J. 191, 227	
Pessin, Neil 25	Sheppard, Dorindia 84	Vergon, Keren S. 27, 210	
Peter, Pecora J. 89, 123, 182	Sheridan, Matt 179	Von Waldner 221	
Piecora, Beth 27	Smalling, Susan 218	Wagner, Mary 120	
Pimentel, Sandra 85	Smith, Christopher L. 98	Walrath, Christine M. 160	
Pinto, Allison 99	Smith, Corvette 123	Wandersman, Abraham 43, 68	
Pires, Sheila A. 149	Smith, Cynthia 80	Wang, Rui 21	
Pirtle, Keith R. 91	Southerland, Dannia G. 95, 96	Wasserman, Gail A. 102	
Plum, Kathleen C. 92	Starin, Amy C. 18, 141	Wehrmann, Kathryn C. 18	