Chapter Eleven

Creating Integrated Service Systems

Evaluation of the Privatization of Child Welfare in Florida: An Organizational Analysis

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Introduction

The Florida 1996 Legislature mandated the privatization of child welfare services (known in Florida as Community-based Care; CBC) through the use of a lead agency design. The intent of this statute was to strengthen the support and commitment of local communities to the "reunification of families and care of children and their families," and to increase the efficiency and accountability of services.

In fiscal year (FY) 2003-04, the Florida Department of Children and Families (DCF) contracted with the Louis de la Parte Florida Mental Health Institute, University of South Florida to conduct an evaluation of the 11 lead agencies and 28 counties in which CBC was operational. Lead agencies included Child and Family Connections, ChildNet, Inc., FamiliesFirst Network, Family Continuity Programs, Family Support Services of North Florida, Inc., Heartland for Children, Inc., Hillsborough Kids, Inc., Partnership for Families, Inc., Partners for Community-Based Care, YMCA Children, Youth & Family Services, Inc., and United for Families, Inc. The goal of the evaluation was to provide policymakers with concrete information and recommendations about next steps and mid-course corrections. The following research questions were the focus of the organizational analysis component of the evaluation:

1. How effective is Community-based Care at designing and improving systems and services for child protection?
2. How effective is Community-based Care at involving the community in child protection, both as service partners and as resource contributors?

To address the design and improvement of services, the organizational analysis examined how lead agencies were organized and provider networks were structured. To evaluate community involvement, the analysis looked at how services were accessed by lead agencies and what types of community governance boards had emerged. This summary describes results of organizational analyses for these questions.

Methods

To describe the organizational and community involvement components, 11 lead agency CEOs were asked to complete a 30 question survey covering: (a) community governance/participation, (b) financial risk, (c) differences in lead agency service systems, and (d) lessons learned in CBC implementation. The CEOs were also asked to provide any available supporting documents related to these areas.

In addition, the project team asked each Community Alliance Chair and Vice Chair to provide information on Alliance membership, and to complete a survey regarding examples of connectedness to lead agencies and CBC. Community Alliances are comprised of key stakeholders actively involved in the community. Community Alliance Chairs and Vice Chairs also were asked to submit pre-existing documents such as meeting minutes to show evidence of interaction with lead agencies.

Qualitative analysis of the data from the surveys and documents was conducted by independent review with coding of the data by multiple investigators. Coding was completed according to coding schemes developed by the investigators based on the survey protocols.

Results

Question 1: How effective is Community-based Care at designing and improving systems and services for child protection?

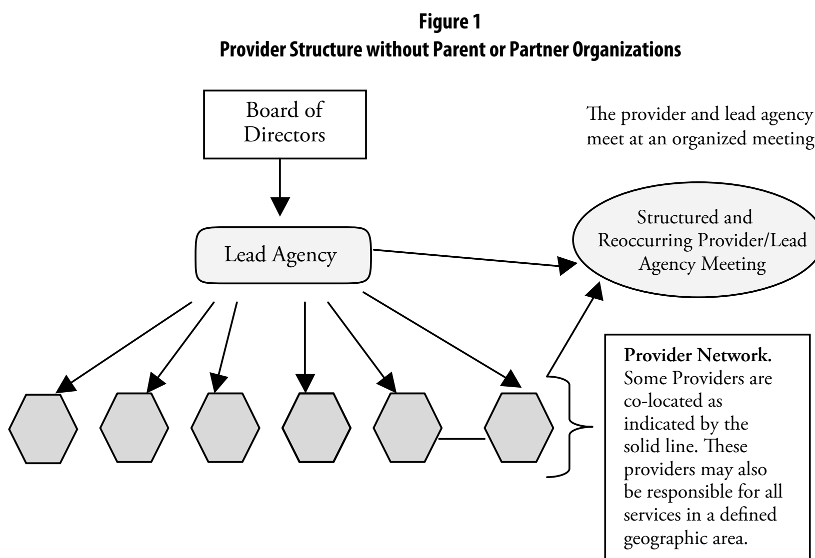
While there are multiple components used to describe organizational structure (i.e., complexity, formalization, and centralization), this analysis addressed the component of complexity (Hall, 1996). Knowing the level of complexity of an organization is important because it can dictate how communication and interaction occur throughout the organization.

The degree of complexity in an organization is measured by the amount of horizontal differentiation, vertical differentiation, and spatial dispersion (Fitzgerald, 2002). In terms of horizontal differentiation, all lead agency organizational charts examined for this evaluation (n = 7) showed four or five different departments/divisions across their organizations as indicated by a distinct personnel title. In all, approximately eight different titles appeared across the organizations that represent the varied divisions of the lead agencies and reflect distinct areas of specialization, including titles such as chief financial officer, quality assurance, and client services/case management.

While horizontal differentiation was consistent across the lead agencies, analysis of the lead agency organizational charts showed varying amounts of vertical differentiation. Four lead agencies had an average of three persons between the lowest and highest levels of the organization. In contrast, the remaining agencies had an average of 4.6 persons between the lowest and highest level of the organization. While the difference may seem negligible, the group with the higher vertical differentiation has two more people between the lowest level and the top-level administration. The hierarchical increase could require more process and communication standardization than that needed in the less vertically differentiated agencies. Two organizations had greater spatial dispersion because services were spread across the county or counties they served through service centers.

With respect to the CBC lead agencies' relationship with the provider network, the analysis identified three models to describe results related to provider network configurations and their relationship to the lead agency, including: (a) a provider structure that maintains parent or partner organizations that provide either all, or part, of the services related to case management, foster care, adoption, and crisis intervention; (b) a more traditional provider model that excludes parent/partner organizations (see Figure 1); and (c) a model that depicts the use of service centers in the provider structure for provision of services to a defined geographic area.

Figure 1
Provider Structure without Parent or Partner Organizations



Question 2: How effective is Community-based Care at involving the community in child protection, both as service partners and as resource contributors?

Alliances generally reported that they were comprised of those members specified in the statute, in addition to members at large from each county within the Alliance's domain including: DCF, county government, juvenile welfare, school district, court system, United Way, and the Sheriff's Office.

Some of the Alliances reported that while there was a preliminary communication process in place to discuss issues with their respective lead agency(ies), the lead agency was too new to warrant much critical feedback. In these cases, Alliances seemed pleased that the lead agency was routinely providing information on their transition process. In some communities, the Alliances had been able to assist new lead agencies through their members' collective experience in areas such as foster care recruitment.

Several Alliances, however, reported that they were not able to make recommendations to their lead agency because DCF Central Office has made it clear that the Alliance was "advisory only," and therefore, in the opinion of many Alliance members, has no authority. One Alliance Chair explained that while they might occasionally make recommendations to their lead agency, the communication process primarily involved listening to presentations and receiving updates, rather than being asked for recommendations.

Many Alliance Chairs were concerned that their members did not feel like they were contributing stakeholders. They expressed a need for more ongoing dialogue, as many Alliance members were only passively receiving information. Chairs suggested that lead agencies should actively solicit feedback from Alliance members via open-ended questions regarding their system of care. Facilitators and barriers identified by Alliance leadership are summarized in Table 1.

Conclusion

Analysis of the organizational structures of the CBC lead agencies revealed differences in their level of complexity across the state. While the agencies were consistent in the amount of horizontal differentiation, they varied on their level of vertical differentiation. With regard to provider network structure, three models emerged representing how lead agencies are organizing service delivery for CBC. These models included those agencies with partner/parent organizations involved, the traditional model that does not involve partner/parent organizations, and a model that includes service centers. The differences in provider network structures would suggest that CBC lead agencies develop their provider networks based on the availability of resources in their communities while seeking ways to reach all of the children and families in their service area.

The majority of Community Alliances reported that child welfare is a standing agenda item but several felt limited by their advisory role and expressed desire for more involvement in local system of care development. Community Alliances are potential community governance partners, but clarification is needed regarding their authority, and their role vis-à-vis the lead agency boards of directors and other

Table 1
Facilitators and Barriers to Communication

Facilitators
• When DCF/lead agency is receptive to Alliance Chair's request for further engagement • High quality of professionalism and leadership of Lead Agency administration • Excellent Communication between DA and lead agency CEO • When lead agency exceeds community's initial expectations • When DA is member of the Alliance and any other pertinent subcommittees • When lead agency is responsive to Alliance's requests for information • Email and/or newsletter updates
Barriers
• Secretary and Central Office DCF have made it clear that Alliances are "advisory only" • Alliances that cover several counties and multiple lead agencies may lose local authority and momentum in shaping local systems of care • Alliances in less populated areas feel other Alliances are driving decisions at the state level • No incentives to be an Alliance member, such as administrative support, authority, or pay

community stakeholder groups. Legislatively appropriated incentives for Alliance membership and engagement in child welfare issues should be considered. Also, more direct communication is encouraged between DCF central office and the Community Alliances—for example, through legislative updates on child welfare related bills—so that the Alliance members have an opportunity to add their perspectives to influence policy.

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Topical Discussion

Applying the Systems of Care Framework to Advance Comprehensive Prevention and Resilience: Implications from an Environmental Scan of SAMHSA-Funded Initiatives

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Introduction

Given the field's growing focus on comprehensive approaches that include mental health promotion, prevention of disorders, early intervention, and intensive intervention/treatment to improve outcomes for children and adolescents, it is urgent to understand the challenges to cross-systems work and to identify strategies for overcoming barriers. This paper summarizes a topical discussion that addressed findings from the authors' environmental scan of nine sites across the country that have received both Systems of Care (SOC), and Safe Schools/Healthy Students (SSHS) grants from the Substance Abuse and Mental Health Services Administration. The purpose of this scan was to identify both successes in collaboration across systems and challenges to the coordination necessary to build comprehensive community approaches to prevention and early intervention. The emerging themes pose issues for policy research about collaboration and system transformation.

Method

Literature was reviewed to identify the dominant theoretical approaches to promotion and prevention, particularly current research related to preventing the trajectory toward serious mental health and substance abuse disorders in young people. The literature reviewed suggests that programs that implement comprehensive approaches show promise for preventing multiple negative outcomes, emotional and behavioral problems for adolescents (Greenberg, Domitrovich, & Bumbarger, 1999; SAMHSA, 2002). Research regarding reduction of common risk factors and building protective factors—on which comprehensive programs are often based—was reviewed (USDHHS, 2001b; Osher, Dwyer, & Jackson, 2004, Appendix A).

This environmental scan was focused on the perceptions of project directors from the SSHS and SOC grant communities. SSHS is a collaboration among the U.S. Departments of Education, Health and Human Services (SAMHSA) and Justice that awards grants to local education agencies (LEAs) working in partnership with local law enforcement and mental health agencies to ensure a comprehensive approach to violence prevention and healthy development. The SOC grant program provides funds to State or local mental health departments to assure that children and adolescents with serious emotional disturbance receive access to comprehensive, integrated, individualized home, school, and community based services. Collaboration is a core component defining both programs.

Through cross-mapping from lists of grantees of the two programs, the authors identified nine sites across the country that have received both SSHS and SOC funding to provide mental health interventions for children and adolescents. Open-ended interviews were conducted with the 18 project directors to elicit their perceptions regarding key elements that promote or inhibit collaboration among multiple agencies. Interview questions addressed themes identified in the literature reviewed regarding comprehensive mental health promotion, prevention, early intervention, and intensive intervention services; of risk and protective factors; and of factors involved in collaboration. The questions clustered into the five elements listed below:

- The role of schools, including issues of lead agency
- Definition of prevention: shared values, operations, planning
- Collaboration successes and challenges
- Other challenges
- Relationship to state efforts to advance mental health system transformation

Results

Informants reported that substantial collaboration occurs between these initiatives, but true integration and systemic change remain elusive. Interdisciplinary work is not easily done; professionals in the mental health and education systems have different vocabularies and different approaches to problem-solving. Although progress has occurred, buy-in to deep collaboration, and the norm of joint decision-making, particularly for the education system, remains a major challenge.

Some frustration was expressed regarding the concept of *lead agency*. Although legislation requires collaboration, each agency desires lead agency status because of how funding comes down the pipeline. Differences in program direction were also identified as a barrier. Decision making in the SSHS initiative is guided by the LEA as the lead agency with input from its partner agencies, and is broadly focused on global objectives and outcomes in the community. The SOC model, on the other hand, is more likely to be guided by the identified and expressed needs of the targeted children and families served. Informants recommended that collaborations require a council where all decision-makers sit.

Although both initiatives have the goal of building infrastructure for systemic change based on theories of comprehensive interventions to reduce risk and build protective factors across service systems, operationally they tend to focus on discrete programs. SOCs are coordinated by State Mental Health Authorities (SMHAs) while SSHS initiatives are not, and further, informants suggest that SMHAs have not routinely been kept informed of local efforts. Three communities with strong SOC initiatives appear to have had a positive impact on SSHS with regard to collaboration, access to schools, and buy-in to the concept of the continuum, and it would seem advantageous for coordinating authorities for the two programs to find ways to facilitate development of joint initiatives.

Barriers were also perceived at the local administrative level. Initiatives were often undermined by changes of people in positions of authority across agencies; new leaders often ignored prior commitments. Informants perceived that education administrators were the most difficult to engage in recognizing the need for interagency work. Some respondents suggested that more explicit expectations for collaboration by federal funding agencies could provide positive pressure for the efforts necessary for sustained integration and systemic change.

Comments from the Field

Participants in the topical discussion reported that they experience the difficulties that result from categorical programs and funding, with their diverse requirements. They understand the benefits of comprehensive initiatives that build on collaboration, approaches that the research supports. They seek opportunities to practice what the research preaches if the policies would allow them to do it.

They suggested new focus on integrating the measures of collaborative groups.

- develop a structure for analyzing and presenting data from all groups
- organize key indicators to focus on needs, assets, and supports across groups
- provide joint feedback to agencies and families

The also stressed the importance of re-structuring relationships and funding to promote collaboration

- *county level*, e.g., Children's Services Council to address county systemic issues through a public mental health model, and also address deep end kids
- *state level,* e.g., Pennsylvania County CASSP coordinators have some blending of funds for preventive work
- *federal level*, e.g., SS/HS funded by three federal agencies

Discussion and Recommendations

This scan found that SAMHSA's two discretionary initiatives (SSHS and SOC) remain distinct and not integrated, even when they have been implemented within the same community. Contemporary mental health promotion and behavioral disorder prevention initiatives face similar fragmentation problems to those that engendered systems of care (SOC) 20 years ago. They are challenged to overcome categorical funding streams that seek to "fix" specific problems in children and adolescents. The research tells us that comprehensive approaches based on risk and protective factor theory may be essential for interventions to be effective in promoting mental health and preventing/intervening early with incipient mental and behavioral disorders (Greenberg, Domitrovich, & Bumbarger, 1999; SAMHSA, 2002, in Frankford et al., unpublished).

Those interviewed fundamentally agree on the importance of prevention and resiliency based approaches, and accept the Institute of Medicine (IOM) population-based classification system of universal, selective, and indicated preventive interventions. To deliver the full range of necessary supports and services, it will be necessary to recognize where intervention is currently occurring and make adjustments to fill gaps and promote coordination.

Research suggests that schools may be strategically the best places to implement child and adolescent prevention interventions. Most children attend school, and school personnel see the full continuum of young people's mental health needs, from emotional and behavioral disorders to serious emotional disturbance. More than three-fourths of children receiving mental health services receive services through the education system, and, for many, this is the sole source of care (USDHHS, 1999b). About half of the care for common mental disorders is now delivered in general medical settings. Primary care providers prescribe the majority of psychotropic drugs for both children and adults. (President's New Freedom Commission) Primary care is the other major setting, after schools, for the early identification of mental disorders in children (USDHHS, 1999b). The community, as a whole, represents the third locus for prevention and early intervention.

The mental health field's systems of care (SOC) approach may offer direction for organizing comprehensive community-based preventive approaches with school and primary health partners. The approach recognizes that "coordinated systems of care, providing a range of services" are required to effectively serve children and their families, as such systems view children in the context of their families and communities, rather than by the singular problems they might have (Stroul & Friedman, 1986).

Outcome measures for children with emotional and behavioral disorders at SOC sites include reduced symptoms, improvements in school attendance and performance, and reductions in law enforcement contacts. These goals are consistent with those of SSHS and other prevention initiatives. SOC values and principles are also consistent with the underlying principles of SSHS:

- Link security with healthy childhood development.
- Take a school-based public health approach.
- Provide comprehensive, coordinated services that are developmentally appropriate.
- Encourage school/law enforcement/mental health partnerships.
- Implement science-based programs with demonstrated outcomes.

Research is needed on how the SOC framework can be applied or adapted to increase collaboration with and sustain SSHS initiatives. To build the public mental health infrastructure that is central to transformation, our findings suggest that successful strategies must be identified for:

- Better integration of school-based and community-based personnel, and to get superintendents, principals, and human services agencies to "own" comprehensive, interagency work with mental health agencies; and
- Greater collaboration and communication between SSHS initiatives and key state partners, especially SMHAs, to align SSHS with states' mental health planning and budget processes, in order to strengthen SSHS sustainability.

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Findings: Examining the Impact of Policy on Collaboration in Systems of Care

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Introduction

The premise of this study is that collaboration is a key principle in developing systems of care to serve children with serious emotional disturbance and their families (Stroul & Friedman, 1986). The purpose of this study was to understand better how policy implementation affects collaboration at the state and community levels that, in turn, contributes to effective systems of care. A related outcome was to inform policymakers about the most effective policy implementation strategies for promoting collaboration. These strategies, often called policy instruments, include legislative mandates, inducements, capacity building efforts, and other system change initiatives (Elmore, 1987). Mandates are rules that govern the behavior of individuals and organizations. The premise of mandates is that goals are achieved by achieving compliance. Inducements are defined as transfer of money or resources to individuals or agencies on a conditional basis, in return for performance of certain actions. Capacity building is the conditional transfer of money to individuals or agencies for the purpose of investment in future human, intellectual, or material resources. System change instruments are those involving the actual transfer of authority among individuals and agencies in order to change the system of service delivery. Multiple policy instruments can be used simultaneously.

Based on previous research, the study identified facilitating and inhibiting factors in three broad areas—attitudinal, behavioral, and structural/organizational—that impact how policy development and implementation contribute to effective collaboration.

Method

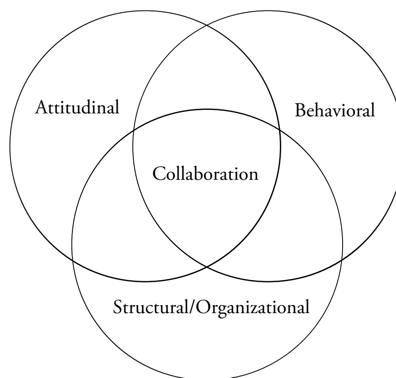
The first phase of the study was a national survey of state mental health authorities to collect information regarding the types of policy instruments that states used to promote collaboration in children's systems of care. A coding scheme was developed to reflect types of policy instruments, agencies involved in the policy, target population, and system-of-care principles. The documents from the states were coded, and the data were entered into a cluster analysis program to identify like groups of states. The solution produced five clusters of states with similar policy instrument approaches.

The second phase of the study was to conduct site visits of two states from each cluster, in order to understand from the perspective of key informants, how policy implementation had affected collaboration at the state and community levels. The research team used a backward mapping approach on-site, beginning each visit with data collection in one or more local communities, and then collecting data at the state level from state policymakers and advocates. Site visit methods included key informant interviews, focus groups, observation of group meetings, and document reviews. Providers and policymakers who participated in the visit were asked to complete the Interagency Collaboration Scale (Greenbaum et al., 2003). Both quantitative and qualitative data were analyzed using a conceptual framework of facilitating and inhibiting factors in three broad areas (structural/organizational, behavioral, and attitudinal) that impact policy development and implementation.

Results

The framework of facilitating and inhibiting factors that effect policy development and implementation (see Figure 1) organizes the study findings.

Figure 1
Domains that Affect Policy Implementation Regarding Collaboration



Facilitating Structural/Organizational Factors. One facilitating factor is a tiered infrastructure of mandated interagency coordination entities. Often, there are tiers at three levels of collaboration: (a) the child and family level, focusing on individual case planning using child and family teams; (b) the county or regional level, with roles of local planning, identification of service gaps, and service development; and (c) the state level, focusing on policy development and barrier reduction.

At the state level within the Executive Branch, one successful strategy is to bring all child serving systems together in one agency. Such an infrastructure can ensure that cross system policies are consistent in promoting collaboration and other system of care values. If child-serving systems are in different state agencies, it is useful to have shared theories of change that view collaboration as an active ingredient in effective systems of care. A common theory of change is often the result of cross-agency visioning and strategic planning activities as well as a history of policy and legislative initiatives that encourage interagency collaboration at state and local levels. When there are interagency initiatives, rotation of leadership roles can promote shared ownership of collaboration. In some states, consent decrees that mandate interagency coordination have facilitated high levels of collaboration. Finally, statewide parent organizations can be useful in playing an advocacy role for stronger collaboration.

Inhibiting Structural/Organizational Factors. Two or more state entities with mandates and resources for children with mental health problems may result in confusion and friction across agencies. Likewise, two or more types of collaborative efforts sponsored by different state agencies with overlapping populations and geographic areas may result in competition for funds and silo structures at the state and/or local levels. Another inhibiting structural factor is financing systems, including managed care arrangements and Medicaid waivers, with funding levels that are not able to support a comprehensive service array and/or flex dollars. Finally, frequent changes in administration and leadership at the state level can detract from the development of collaboration.

Facilitating Behavioral Factors. One of the strongest study findings is that policies with clear accountability mechanisms are associated with high levels of collaboration. Collaboration is strengthened by shared, active use of data by policymakers at state and local levels to drive decision-making, planning, and problem solving.

A series of consistent policies and initiatives that provide moderate resources for collaboration and system of care development facilitates collaboration. Leadership that is visionary, strong, and sustained, by at least one state agency is effective in promoting collaboration. Collaboration may be facilitated by the development of a coherent, cross-agency strategy for the integration of activities into a coordinated approach to system-of-care development.

Inhibiting Behavioral Factors. Behavioral factors that may inhibit collaboration include a history of territorial and turf issues that have created mistrust. Collaboration is not promoted when policies of child-serving agencies do not reflect system-of-care values, including family involvement and collaboration. An additional inhibiting factor is variability in local implementation of collaboration and other system-of-care values and principles.

Facilitating Attitudinal Factors. A shared cross-system vision and support for system-of-care values and principles, coupled with mutual respect for each other's mission, facilitates interagency collaboration. Other facilitators are a long-term cross-agency focus on barrier reduction at the state level, and a perception among stakeholders that there is willingness to compromise regarding goals and strategies. Finally, adequate local authority to "do whatever it takes" to serve children in their homes and communities fosters interagency collaboration.

Inhibiting Attitudinal Factors. When there is competition among cross-agency partners for resources and power, territorial and turf issues inhibit interagency collaboration. Belief systems that focus on blaming and deficits rather than a family-centered and strengths-based approach discourage family involvement and collaboration. In addition, mistrust among system partners, including a mistrust of parent's perceptions about the system of care, reduces collaboration and cooperation.

Conclusion and Policy Recommendations

The study findings lead to a series of policy recommendations. Infrastructures, such as tiered coordinating entities, a super agency that includes several child-serving systems, or a Children's Cabinet, are useful structures for promoting collaboration. This is particularly true when these structures use their authority to convene and task partners on a regular and ongoing basis. Interagency collaboration needs to be viewed as an essential element of the culture of serving children and their families. Strong and sustained leadership, across child serving agencies, promotes effective collaboration.

Legislation can facilitate and institutionalize interagency collaboration. Policies that are clear in their statement of the population to be served, will lead to more positive outcomes regarding collaboration. A shared causal theory of change also is useful in promoting collaboration and effective systems of care. Policies should promote local autonomy in the use of human and financial resources, whether the resources are modest or substantial.

Finally, policymakers should encourage and support efforts to strengthen interagency collaboration and establish systems of care, whether or not these efforts begin at the local or the state level.

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Intensive In-home Therapy as Early Intervention: Results from a Clinical Trial

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Introduction

Children who get in trouble with the law are often placed in programs to complete a course of mental/behavioral health treatment as an alternative to detention or other punitive sanctions. Such programs usually are conducted in congregate care facilities (group homes or residential treatment centers; Sickmund, 2000), are expensive (estimates range to more than $350 per day per child; New York City Department of Juvenile Justice, 2001), and have little evidence to suggest that they produce positive behavior change in children. Preventing such placements through the provision of needed mental health services in a child's own home may provide a cost-effective alternative. A randomized clinical trial to examine the effectiveness of intensive in-home services in preventing juvenile court contact and placement was conducted for children who were at increased risk of such involvement with the court. Juvenile court contact, placement, and changes in custody were examined to determine the differences between those who received in-home services (treatment group) and those who received referrals for alternative services available in the community (comparison group). Additional information on differences between groups was generated through analysis of school performance and assessment of youth psychosocial and family functioning.

Study Design

A total of 240 families were recruited from a variety of referral sources including the local juvenile court, city and county school districts, and the Community Service Agency (CSA). Following a face-to-face intake interview, participants were assigned (stratified by race, sex, and referral source) to the treatment or comparison group. Those in the treatment group received four to six months of intensive in-home therapy based on the principles of the Multisystemic Therapy model (MST; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998); those in the comparison group received contact information for three to five organizations in their geographic area that specialized in the issues that the parent/primary caregiver had identified as their most pressing concern. Follow-up interviews were conducted face-to-face at six months and by phone at 12 and 24 months post-intake.

The sample was nearly evenly split according to gender (51% male), and the majority of youth (81.4%) were African American. The largest proportion of youth (48.3%) was in the 12- to 14-year-old age group (range 2 to 15; average age 12.9 years). The most common source of referrals was the local juvenile court (40.7%), followed by the CSA (26.3%), schools (18.6%), and self-referrals (14.4%).

Measures

An extensive intake interview was conducted to gather information on the presenting problems, current family, school, and social functioning, as well as information about the parents' background such as education, employment, mental health, and alcohol and drug use history. During the intake interview and again at six months post-intake, youth psychosocial functioning was assessed using the Child Behavior Checklist (CBCL; Achenbach, 1991), the Youth Self-Report (YSR; Achenbach, 1991), and the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 1997). Involvement in delinquent behavior among participants was assessed with the Self-Report Delinquency Scale (SRDS; Elliott & Ageton, 1980). Family functioning was measured with the Family Assessment Measure: General Scale (FAM:GEN; Skinner & Steinhauer, 1993) and the Family Adaptability and Cohesion Evaluation Scale (FACES III; Olson, Portner, & Lavee, 1985). The CAFAS, SRDS, and the Delinquency sub-scale of the CBCL were repeated at 12 and 24 months following intake, along with a parent and a child interview that contained items concerning perceived change in primary concerns, and changes in school, social, legal, and family status since the previous interview.

Primary data were requested from schools at 12 and 24 months following study admission, including number and type of suspensions, number and type of absences, and average academic and conduct grades during the follow-up period. Overall, 74% of the requests for information from schools were completed. Analysis of potential bias in the respondent pool demonstrated no significant bias in those for whom information was vs. was not obtained based on demographic variables, group (treatment vs. comparison), and presenting problem.

The local juvenile court was asked to provide information on contacts with study participants, including type of contact, charges, disposition of case, custody changes, and placement in a juvenile facility at 12 and 24 months after program admission. Thanks to the high level of cooperation from the court, 100% of the information requested was provided. Given that contact with juvenile court is one of the primary outcome indicators, the accuracy and completeness of the data provided by the court is an essential factor in the quality of the evaluation of this project.

Results

Children in the study faced significant life challenges. Almost 20% of the families in the study reported that they lived in a high-crime area. Approximately 18% of the families had an income of less than $10,000 per year, and only 10% of children in the study lived with both biological parents. Almost half of the study participants (47.1%) had been to the principal's office within the month prior to intake, and over 75% in each group had been suspended from school at least once in their lifetime. Almost half (48.8%) of the children in the study had repeated at least one grade, and one in four participants (25.0%) had a history of running away from home.

Concern about oppositional behavior was identified by the majority of parents (67.8%) as the primary referral problem. The next most frequently cited presenting issue (12.1%) was problems with peers. School problems were the third most frequent concern (9.6%), family problems were next (5.4%), followed closely by concern about illegal behavior (5.0%). There was no significant difference in presenting problems between the two groups.

Analysis of differences in the primary outcome indicators (juvenile court contact, out-of-home placements, change in custody) suggested a slight trend toward the treatment group having fewer juvenile court contacts over 24 months (52.5% vs. 60.0%), fewer juvenile court placements (35.8% vs. 36.7%), and fewer changes in custody (10.0% vs. 12.5%) than the comparison group. However, the differences were not statistically significant.

Information gathered from schools demonstrated differences between groups in academic and conduct grades during the follow-up period at both the 12- and 24-month points. Participants in the treatment group were significantly more likely to earn *satisfactory, good, or excellent* conduct grades than those in the comparison group at each follow-up (12-month: $t\ (144) = -2.20$, $p = .03$; 24-month: $t(106) = -6.90$, $p < .001$). Those in the treatment group also were more likely to be earning adequate academic grades (A, B, or C) than those in the comparison group; the difference between groups was significant at the 24-month follow-up, but not at the 12-month time period (12-month: $t(149) = -1.34$, $p = .182$; 24-month: $t(110) = -3.53$, $p < .001$). The total number of suspensions experienced during the 24-month study period did not differ by group. Total absences from school during the study also did not differ by group.

Several of the assessments were administered only at intake and six months, including the CBCL, YSR, FAM:GEN, and FACES III. The first three measures showed mixed results, with trends generally favoring more improvement in the treatment group than in the comparison group. No differences in family functioning between the treatment and comparison groups at either time point were demonstrated by the FACES III. The CAFAS, which was administered at all four time points, showed significant improvement for both groups in the Role Performance domain, but virtually no difference between groups or across time on other domains.

Discussion

The results of this clinical trial examining the effectiveness of intensive in-home services with children at-risk for out-of-home placement demonstrated a substantial amount of success for children and families in the program. Participants in the treatment group showed trends toward fewer negative juvenile court outcomes (though differences were not statistically significant), significantly better average academic and conduct grades, and improvements in youth psychosocial functioning.

Analysis from this project presented elsewhere (Hurley, Vander Weg, & Goldsmith, 2004) suggests that the level of therapist adherence to the MST model is important in achieving positive outcomes for children and families, and that adherence may be affected by family, client, and therapist characteristics. Preliminary analysis of the data in this study indicates that outcomes may be more positive for those in the treatment group whose caregivers reported higher levels of therapist adherence. Future research focusing on the mechanisms through which therapist adherence impacts children and families would make a significant contribution toward a greater understanding of optimal approaches to treatment and prevention for youth at high risk of negative involvement with the juvenile justice system.

As more funding entities require agencies to make use of evidence-based treatment models, it becomes of greater importance to examine the effectiveness of those models with a variety of populations. In addition, clearer explication of the processes involved in achieving positive outcomes is needed for each therapeutic model. Much work remains to be done in understanding the complex links between the level of therapist adherence as reported by caregivers and the outcomes achieved by children and families. Data gathered from this project will continue to be used to examine these important questions.

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The Multiple Needs of Youth Entering the Juvenile Justice System

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Introduction

Most needs assessments of youth involved with departments of juvenile justice (DJJ) have focused on detained populations, such as youth who have been incarcerated because they were found guilty of a serious crime or are deemed to pose a threat to the community. Among this population, high rates of psychiatric disorders, educational failure, and family problems have been observed (Garland et al., 2001; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002; Wasserman et al., 2003). However, little is known about the needs of a larger population of juvenile justice youth—those who come into contact with DJJ but are not incarcerated because their violation of the law does not merit immediate detention, they are awaiting trial, or their case is otherwise resolved. It is widely agreed that many of these youth would benefit from targeted interventions to reduce the likelihood of repeated offenses and future incarceration. Although some state juvenile justice systems have adopted health screening procedures for youth in detention (Cauffman, 2004), there are few statewide efforts that use validated instruments to systematically screen youth at the first point of contact with DJJ before the case is resolved.

Method

This research was undertaken to validate a health risk and needs screening intake instrument for the Maryland Department of Juvenile Services (MDJS); it involved having 231 youth age 12-17 and one of his/her caregivers present for intake at one of two urban or four rural jurisdictions from May 2002 – April 2003.

Following intake, the officer explained that MDJS was collaborating with Johns Hopkins University to gather additional information about youth to refine the intake process. A researcher contacted interested families within two weeks of intake.

Following the ascertainment of consent/assent and a brief reading assessment, the youth and parent individually completed a paper and pencil self-administered questionnaire compiled from well-validated and widely used measures to determine the youth's level of need across functioning domains. These questionnaires were completed in the youths' home or at another convenient private location and required less than one hour. The research was approved by the Committee on Human Research of Johns Hopkins University Bloomberg School of Public Health and the State of Maryland.

The Behavioral and Emotional Rating Scale (BERS; Epstein & Sharma, 1998) was administered to parents to assess the youth's behavior, emotion, education, and family needs. The Caregiver Strain Questionnaire (CSQ; Brannon, Heflinger, & Bickman, 1998) was administered to parents to report family needs. Parents also completed the Child Behavior Checklist (CBCL; Achenbach, 1991) to assess their child's behavior. Youth self-reported their behavior, education, emotion, family, and somatic health needs using the Child Health Illness Profile—Adolescent Edition (CHIP-AE; Starfield et al., 1995). The Children's Depression Inventory (CDI; Kovacs, 2000) was administered to youth to self-report emotional needs. The Massachusetts Youth Screening Instrument (MAYSI; Grisso, Barnum, Fletcher, Cauffman, & Peuschold, 2001) was administered to youth to self-report emotional and substance use needs. Finally, youth self-reported substance abuse using the Simple Screening Instrument (SSI; Center for Substance Abuse Treatment, 1994).

Scores for each measure were computed using the algorithm provided by the developing author. Proportions are used to describe youth who scored above the problem threshold on a requisite number of measures used to assess each functioning domain. The number of scales or subscales for which a youth scored above the positive threshold was summed to determine whether the youth demonstrated a need within that domain. In order to report conservative estimates of need, a youth must have scored above the positive threshold on at least more than one scale or subscale within the domain. For example, only youth who met the problem threshold on four out of a possible seven administered subscales were identified as likely to have an emotional need. The number and proportion of youth demonstrating a need across domains is reported.

Results

This sample was highly representative of statewide youth at MDJS intake on the basis of age, race, gender, and offense severity. Only 3% of youth were less than age 12 years of age; 31.12% were between the ages of 12-14; 61.03% were between the ages of 15-17; and 4.72% were 18 or older. Nearly half of the sample (48%) reported being African-American, 46.7% were Caucasian, 3.9% were Hispanic, and less than 1% identified themselves as being Native American or of mixed race. Seventy-four percent of the sample was male. The offense level and type of crime also represented the MDJS intake population, with most youth (73.1%) charged with a misdemeanor offense and nearly half (44.9%) of youth charged with the least serious offense category.

Table 1 presents the proportion of youth identified as meeting the problem threshold on a requisite number of scales or subscales within each functioning domain. Youth who completed all scales within that domain compile the denominator. Over half of youth demonstrated family problems and education problems. Almost half of youth demonstrated a substance use problem. Less than one-quarter of youth demonstrated behavior, emotion, or somatic health problems.

Table 1
Youth Demonstrating a Need within Functioning Domains and Number of Positive Subscales Required

Domain	*Proportion and Number of Youth with Need*	*Number of Positive Subscales Required*	*Scale*	*Subscales Used*
Behavior	22.0% 49/223	2/4	BERS CBCL CHIP	Interpersonal strength Aggression and Delinquency School behavior
Education	65.8% 150/228	1/2	BERS CHIP	School functioning Academic performance
Emotion	21.3% 49/230	4/7	BERS CDI MAYSI	Interpersonal and Affective strength Total score Depressed, Anxious, Somatic complaints, Suicide
Family Needs	59.0% 135/229	1/3	BERS CSQ CHIP	Family involvement Global strain score Family involvement
Somatic Health	18.0% 41/229	2/3	CHIP	Overall satisfaction, Physical discomfort, Limitations of activity
Substance Use	46.5% 107/230	1/2	MAYSI SSI	Alcohol and drug Total score

Table 2 presents the proportion of youth with a need across multiple functioning domains using the definition of need provided in Table 1. Only youth who completed all scales across domains were eligible for inclusion in the denominator. Almost all youth demonstrated a need within at least one domain. More than half (64.4%) of youth demonstrated need within two or more domains. Only 2.25% of youth demonstrated a need in all six domains of functioning.

Table 2
Youth Demonstrating Needs across Functioning Domains

Number of Functioning Domains Positive	*Number of Youth (N = 222)*	*Proportion of Youth*
1 or more	203	91.4%
2 or more	143	64.4%
3 or more	93	41.9%
4 or more	48	21.6%
5 or more	22	9.9%
6	5	2.25%

Discussion

To the best of our knowledge, this is the first published systematic investigation of the health, mental health, substance abuse, and psychosocial needs of youth at DJJ intake prior to resolution of their case that is representative of a statewide DJJ intake population. The investigation uses highly reliable and valid measures that illicit responses from both youth and parents.

The majority of youth demonstrated multiple needs across life domains, requiring at minimum further evaluation and possibly intervention. Unlike research focused on detained or adjudicated populations, the present study did not find high rates of mental health problems. Of the youth who completed all behavior and emotional health measures, only 8.5% were identified with needs in both domains. This suggests that although mental health, behavioral health, and emotional health are frequently combined into a single service delivery system, youth may benefit from services that directly target internalizing or externalizing mental health problems. However, the range and specialization of services available to DJJ youth may inhibit such a reasonable distinction. Providing effective services to this population requires considerable collaboration between service sectors.

Given the authors' strict criteria to define need within domains and the self-reported nature of the measures, these data are likely under-estimates of true problems. Requiring that youth meet the problem threshold on fewer measures would increase the proportion of youth demonstrating a need within each domain. Despite the researchers' assurance of confidentiality and anonymity to the participants, the investigation took place within the context of MDJS, often with a court case pending. Although no information was shared with MDJS, the youth and parents still may have been more likely to under-report problems to avoid perceived punitive sanctions.

Although this investigation was not intended as an epidemiologic assessment of need, it does indicate that among a diverse and representative population of DJJ youth, there exists a range of health and psychosocial needs. This population constitutes a larger group of youth than those who are detained. These youth are poised to receive interventions that will decrease their problem behavior, improve their emotional well-being, and prevent recidivism to DJJ.

This research also demonstrates that needs screening at the point of intake generates useful and important information which can be used to not only identify youth problems, but also for the management of resources within juvenile justice systems. Collecting needs information at intake provides agencies with the data necessary to justify the delivery of health-related services. Because large numbers of youth will be identified as having a need during intake screening, departments of juvenile justice will struggle with how to appropriately use intake data and partner with other child serving agencies to meet the needs of youth.

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Juvenile Justice Outcomes of Youth in Systems of Care: Comparison Study Results

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Introduction

Research shows that a large overlap exists between those with mental health problems and those involved in the correctional system (Lurigio 2001; Potter & Jenson 2003; Teplin, Abram, McClelland, Dulcan & Mericle, 2002). Many youth who commit criminal offenses suffer from mental health problems, and many youth who receive mental health services commit criminal offenses (Atkins et al., 1999; Dembo, Voie, Schmeidler & Washburn; 1987; Foster, Qaseem & Connor, 2004; Rosenblatt et al., 2000). Although the exact proportion of mentally ill youth involved with the juvenile justice system is unknown, youth with mental health problems are likely over represented in the juvenile justice system (Cocozza & Skowyra 2000; Potter & Jenson 2003, Teplin et al. 2002). Offenders with mental illnesses are often placed in detention where they receive no mental health services (Gurian-Sherman, 2001). Because evidence suggests that there is a strong association between mental illness and involvement with the police and the correctional system, cross-agency collaboration in the community may address the complex needs of those with emotional and behavioral problems and reduce future criminal offending (Lurigio 2001).

Due to the overlap of youth who are involved in the juvenile justice system with mental health and/or substance abuse problems, a comprehensive system-wide approach is necessary to meet the needs of these youth. The cross-agency collaboration and service coordination are central elements of systems of care funded by the Center for Mental Health Services (CMHS) as part of the Comprehensive Community Mental Health Services for Children and Their Families Program. The system of care approach to treatment requires that child-serving agencies such as mental health, social services, and juvenile justice work together to develop an individualized treatment plan for youth. Presumably through cross-agency interaction, outcomes for youth will be improved in multiple areas such as mental health, school performance, and less involvement with juvenile justice. This study examines the effectiveness of systems of care in reducing the incidence of juvenile justice involvement among youth with behavioral and emotional disorders and the clinical outcomes of youth involved in the juvenile justice system.

Method

Participants

Participants were drawn from youth and families who participated in the comparison study component of the national evaluation of the Comprehensive Community Mental Health Service for Children and Their Families Program. The 1997 comparison study collected information from four communities: two CMHS-funded system-of-care communities and two matched non-funded comparison communities in Alabama and Nebraska. Given the availability of extensive juvenile justice information, this paper focuses primarily on the information about the juvenile justice involvement of children participating in the Alabama comparison study. The present sample included 202 youth served by the system-of-care grant-funded program, the Jefferson County Community Partnership, that includes the city of Birmingham, and 189 youth from the matched community located in four contiguous counties that are served by the Montgomery Area Health Authority.

Measures

A variety of information was compiled from the national evaluation of the Comprehensive Community Mental Health Service for Children and their Families program data base which included a series of standardized scales administered to parents within an interview format. The Child Behavior Checklist (CBCL; Achenbach, 1991)) is a widely used caregiver report measure that assesses children's emotional and behavioral problems (Achenbach, 1991). The Child and Adolescent Functional Assessment Scale (CAFAS;

Hodges & Wong, 1996) is a widely used instrument that assesses the degree to which a child's emotional, behavioral, or substance abuse disorder is disruptive to his or her functioning in each of several psychosocial domains (Hodges and Wong, 1996). The Behavioral and Emotional Rating Scale (BERS; Epstein and Sharma, 1998) identifies the emotional and behavioral strengths of children (Epstein and Sharma, 1998.). The juvenile justice records were compiled using the administrative data provided by Jefferson County Family Court and Montgomery Area Probation Administration Office.

Results

The implementation of interagency approaches by the Jefferson County Community Partnership includes particular focus on children with mental health or behavioral problems who are involved in the juvenile justice system. The differences in the referral sources of the children served by the two communities reflected the juvenile justice focus of the system-of-care community in Jefferson County, Alabama. Among these children, 63.9% were referred to the program by the court and corrections system. The corresponding figure in Montgomery, Alabama, was 3.3%. In both communities, youth with prior juvenile involvement were older, more likely to be male and more likely to come from lower income families. They had more externalizing problems (as measured by CBCL) and higher functional impairment (as measured by CAFAS). In addition to externalizing problems, children with prior juvenile justice involvement who entered the Jefferson County system of care also exhibited more serious internalizing problems (as measured by CBCL). There were important differences between the two communities with regard to their age, family income, risk experiences, child behavior and functioning. These differences must be considered in both the analysis and interpretation of the outcome data[1].

The juvenile justice records that covered a period of 36 months (18 months prior to intake and 18 months post intake date) were examined to assess the extent of juvenile justice involvement of the children in the comparison study. Among the 202 children served by the Jefferson county system of care, 135 children (66.8%) had juvenile justice records prior to enrolling into the system of care. In Montgomery, 18 out of 189 (or 9.5%) of the children participating in the evaluation had contact with the juvenile justice system prior to intake. The proportion of children charged with various crimes decreased significantly to 46.5% ($z(202) = 4.1$, $p < .001$) during the first 18 months of services in the Jefferson County system of care. Conversely, the rates of juvenile justice involvement during the first 18 months of services among children in Montgomery, Alabama, increased to 13.7%[2]. A multivariate analysis of changes in crime rates in the two communities that accounted for variation in age, gender, family income, and clinical characteristics revealed that the successful reduction in crime rates in the Jefferson County system of care relative to the Montgomery comparison community was even greater once the baseline differences in demographic and clinical characteristics were taken into account[3].

Figure 1 presents the most frequent charges brought against the children in the two communities during the 18 months following entry into services[4]. In the Jefferson County system of care, children were most likely to be charged with status offenses (18.8%) such as truancy, running away, and uncontrollable/ungovernable behavior, followed by offenses that represent danger to persons (12.4%) and offenses involving damage to property (9.8%). In Montgomery, charges of theft were most likely to occur (22.2%), followed by damage to property (19.4%) and offenses involving danger to persons (18.1%). The children in the Jefferson County system-of-care community were less likely to be charged with more serious (Part I) crimes than children in the comparison community. In the system-of-care community, 31.0% of charges filed were Part I crimes, while in the comparison community the corresponding number was 39.4%[5].

Author notes
[1] The sample descriptive statistics are available from the authors.
[2] The increase was not statistically significant.
[3] The results of the logistic regressions with and without additional controls are available from the authors.
[4] The charges were classified using the Alabama State Code.
[5] The User's Guide to Alabama Juvenile Justice Case Records was used to further classify charges into Part I and Part II offenses. Part I offenses include violent and property crimes which are generally more serious. Part II crimes include less serious offenses such as receiving stolen property, possession of a weapon, possession of drugs, trespassing, and status offenses.

Next, a Generalized Linear Modeling method was employed to examine whether mental health outcomes of children involved in juvenile justice system differ in the system-of-care community relative to the comparison community. Figure 2 presents the trajectories of change in the CBCL Internalizing Problems for the children in the two communities. The results indicated that youth with prior juvenile justice contact served by the Jefferson County system of care had shown significantly greater improvement in their internalizing problems than their counterparts in the comparison community ($F\,(242) = 4.165, p < .05$). No significant differences were found in the changes in the externalizing problems.

Figure 1
Types of Offenses Reported in the Alabama Comparison Study Sites

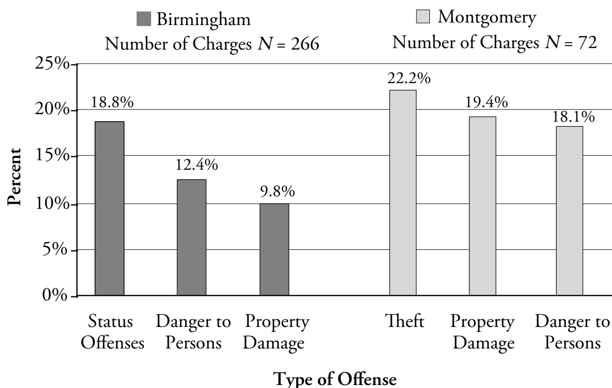
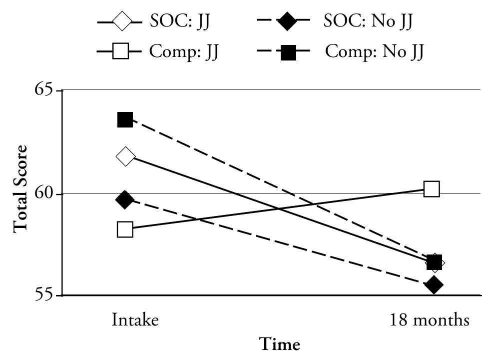


Figure 2
Internalizing CBCL Score by Juvenile Justice Involvement: Intake to 18 Months



Discussion

The findings from the longitudinal comparison study demonstrate enhanced outcomes related to juvenile justice involvement for children in Alabama served in the system-of-care setting, as compared to those served in a services-as-usual environment. The findings confirm previous research that found that improved mental health outcomes of children served by systems of care reduced the risk of juvenile justice involvement (Foster et al., 2004, Foster & Connor, 2005). In addition to the decrease in the number of contacts with the system, children served by the system of care appeared less likely to commit more serious offenses. Youth with prior involvement in juvenile justice system served by Jefferson County system of care showed significantly more improvement in their internalizing behavioral problems relative to their counterparts in the matched comparison community. Given that youth with mental health problems who are involved in the juvenile justice system often exhibit externalizing behavioral problems, it is important to note the possibility of co-occurring internalizing problems for these youth and address these problems appropriately.

There are some limitations that should be considered when interpreting the results of this study. The samples were unequal and small. Further, the the analysis and discussion regarding new offenses examined and compared percentages between the two groups; findings expressed in percentages are particularly sensitive to small sample sizes.

These findings also must be contextualized within the differing organizational structures of these two mental health service environments. The Jefferson County Community Partnership expanded upon State funding for the Family Integrity Network Demonstration (FIND), a project designed to work collaboratively with other public child-serving agencies. FIND teams are outstationed at the family court (juvenile justice) and the Department of Human Resources (child welfare). For systems of care targeting particular agency-based populations, a key element of success may be the organizational placement of mental health workers within those targeted agency environments.

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Project CATCh: Examining a Community- and School-Based Model for Prevention and Mental Health Services in a Rural Community

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Introduction

There has been an increasing emphasis on primary schools to provide mental health services. Schools have become the *de facto* mental health system for many children, with 70-80% of children who receive mental health services being seen by providers in a school setting (Burns, et al., 1995). According to the Surgeon General (US Department of Health and Human Services, 1999), schools are the largest provider of mental health services for children in this country. The President's New Freedom Commission report calls for a transformation of the mental health care system in America (Hogan, 2003). Doing so will require an increased reliance on evidence-based school mental health interventions.

The benefits of providing school-linked mental health services are numerous. Aside from accessing children "where they are" (Weist, Evans, & Lever, 2003, p. 1), schools can facilitate outreach to students, particularly those from disadvantaged or marginalized communities with minimal resources. When families are faced with daily living stressors, mental health services may not be of prime importance. Families may also not recognize the signs and symptoms of more serious impairment in their child, particularly if the student has more internalizing symptoms and does not exhibit behavioral difficulties. For those who do recognize when a problem exists, they may be reluctant to seek services due to stigma about mental health care. Schools can provide outreach that decreases stigma and avoidance of mental health issues by providing services at the school, rather than the clinic, and in a setting more comfortable for parents and their children. School-linked mental health services can also help overcome common barriers to care (Armbruster, Gerstein, & Fallon, 1997; Flaherty, Weist, & Warner, 1996). Families may not have the means to attend a community clinic for a variety of reasons, including financial, insurance, transportation, or limited flexibility with jobs. Providing services in or near school facilities, however, minimizes many of these barriers.

The need for school district collaboration is especially evident in rural, under-served areas, such as Columbia County, Florida, where substance abuse and violence exposure rates are disproportionately high (Slovak & Singer, 2002; Florida Department of Education, 2003). Similar to other rural communities, resources in Columbia County are inconsistently available, with multiple barriers to access. This presents an ideal opportunity for partnering with the school district to increase access to children's mental health services. The National Rural Behavioral Health Center (NRBHC) at the University of Florida has partnered with the Columbia County School District to provide preventative and primary mental health services to rural students and their families. The present research examined community feedback regarding the collaborative program and the lessons learned from this successful school district collaboration.

Method

Researchers at the National Rural Behavioral Health Center (NRBHC) at the University of Florida have partnered with the Columbia County School District to implement and evaluate primary and tertiary mental health services to students and families in Columbia County, Florida. Working in collaboration with the local mental health sector, Columbia Acting Together for Children (Project CATCh) is a federal Safe Schools/Healthy Students site that has invested heavily in bringing community entities (e.g., school, mental health, law enforcement, public health, local business) together to increase

coordinated care for at-risk children. A critical component of Project CATCh is the Prevention Management Team (PMT), which includes service providers and families to identify students' needs and design tailored service plans to best address these needs. Families who participated were referred for services by school staff, typically the school guidance counselor.

We surveyed the 12 school guidance counselors from participating schools, 12 representatives from the community agencies collaborating in Project CATCh, and 12 parents who participated in the PMT process regarding their experience with Project CATCh and the PMT. Frequency data were obtained and analyzed by NRBHC staff. Results were used to advise Project CATCh staff of the perceptions and experiences of participating agencies and families, and to inform and improve procedural issues in the program and the PMT. The respective pen-and-paper surveys were self-administered and included 18-19 questions developed by NRBHC staff. The survey included questions in both Likert scale and open-ended format.

Results

Limitations. The limitations of the survey should be noted. The purpose of the survey was to assess participant satisfaction with the project overall. As such, the results are from a satisfaction survey only and are not intended to identify causal relationships or group differences. Second, the sample size is small and not intended to represent the community as a whole, but rather the specific individuals who participated in the PMT.

Overall, community agency representative responses were positive, suggesting significant benefit to families as well as community agencies. Agencies indicated the program provided more service options for families, and increased inter-agency awareness, collaboration, communication, and sense of unity. Suggestions for improvement included better follow-up with families, more consistent attendance by community members, and increased awareness of Project CATCh in the schools. Of the agencies interviewed, 91% said they understand the service planning process. Eighty-three percent of these respondents agreed that the PMT meeting is convenient to attend and useful for treatment planning, but two respondents (17%) said the process was inefficient. For instance, they indicated that the meeting ran longer than needed.

Guidance counselors from most of the schools in the district were also interviewed. Overall, counselors indicated the program was positive and said they would continue to refer students. Suggestions for improvement included increased feedback from agencies providing services, decreased time between the referral and service provision, and improved follow-up from the families. All felt they could explain Project CATCh to students and families, and 90% felt it was not too involved. However, 43% reported that attending the PMT was inconvenient, and three of the eleven respondents who answered (28%) were dissatisfied with the time between the initial referral and PMT.

Parents reported general satisfaction with the program, stating that it provided expanded resources to children, it educated parents about mental health issues, and "re-instilled faith" in the school system. Parents generally felt comfortable discussing their child's case with the community agencies, but two of the eleven parents who answered (18.2%) reported they were "unsure" about confidentiality issues (see Table 1), which is not surprising given the small community setting.

Table 1
Parent Likert-Scale Responses

	SD	*D*	*MD*	*U*	*MA*	*A*	*SA*
I felt comfortable talking to UF during the assessment	—	—	—	—	—	16.7%	83.3%
I was listened to	—	—	—	—	—	16.7%	83.3%
I felt comfortable talking at the PMT	—	—	—	—	—	16.7%	83.3%
I am worried about confidentiality	54.5%	27.3%	—	18.2%	—	—	—
We had to wait too long for the initial assessment	41.7%	41.7%	—	—	8.3%	—	8.3%
We had to wait too long for the PMT	75.0%	16.7%	—	—	8.3%	—	—
Seeking services through CATCh has been hard	72.7%	27.3%	—	—	—	—	—
I am satisfied thus far	9.1%	—	—	9.1%	—	—	81.8%

Notes
SD = Strongly Disagree, D = Disagree, MD = Mildly Disagree, U = Unsure, MA = Mildly Agree, A = Agree, SA = Strongly Agree

Discussion

Obtaining feedback from community stakeholders, service providers, and families is an essential component of successful community collaboration. To assess participant satisfaction with Project CATCh, self-administered satisfaction surveys were given to community representatives, school guidance counselors, and families. Overall satisfaction with Project CATCh is high. Community agencies, guidance counselors, and families rated the program positively, suggesting the school-linked services have been helpful in providing services to students and their families. Service providers reported being satisfied with the program and noted that it increased community awareness regarding available services for families, and the families themselves indicated they felt more resources were available. However, concerns were expressed regarding the program's efficiency. The primary area in need of improvement was decreasing the waiting time for services. Based on the results of the survey, Project CATCh staff collaborated on methods to improve the process of service delivery. Namely, the interval between the initial referral for services to the actual therapy intake was streamlined to reduce family wait time and initiate services more efficiently. Guidance counselors have responded positively to this change and feel the system is less cumbersome for families.

Preparing the survey and analyzing the results gave us a chance to reflect on additional lessons we have learned during the process of implementing a school-linked program in the context of community partnership. While not inclusive, these guidelines address potential pitfalls and highlight issues to consider in community-participatory research.

First, identifying the needs of the community is vital to program development as well as working toward increasing stakeholders' and community members' perceptions of program acceptability. The obvious first step in building any successful collaboration for prevention and mental health services is to identify the specific needs for services and build motivation to expand current services. Gaining entrance into the school community first requires recognition for the need for mental health services. Second, addressing resistance must be a priority at all phases of program development and implementation. Introducing a new mental health program is more likely to succeed if there is the capability of building on some form of intervention that is already in place. However, despite the existence of a school-based model of mental health services, convincing administrators to incorporate additional services can be a challenge. Third, program developers should consider methods of expanding the investment to increase

the sustainability of the program. Once the administration has accepted the need for services, engaging other school staff in the design of the program increases chances for successful implementation. Further, this decreases the likelihood that community and school partners will be disenfranchised by a common occurrence: termination of school-linked mental health services following the termination of initial funding streams (Owens & Murphy, 2004). Fourth, providing timely follow-up should be a priority of all school-linked mental health service program developers and providers. One of the most common complaints of school staff toward school-linked mental health services was that they referred a student for services and then heard nothing more about the student or how specific concerns were addressed. Fifth, communicating with community members during all phases of the project is key to both program development and sustainability. Indeed, it is essential to build and maintain open communication between all involved parties, especially as the collaborative relationship progresses (Owens & Murphy, 2004). Finally, school-linked mental health programs must always maintain sensitivity to the community's cultural needs and values. The community is, after all, what is being served. Furthermore, maintaining such cultural sensitivity increases the likelihood that a school-linked mental health program can be fully integrated into the network of community resources in an acceptable and accessible manner.

Consideration of these factors, together with self-evaluation and flexibility, will aid in the implementation and sustainability of collaborative community programs, such as school-linked services, which are indispensable providers for under-served children and families.

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