USF
UNIVERSITY OF
SOUTH FLORIDA

A Study of Service Innovations that Enhance Systems of Care:

Expanding the Array of Services using Networks of Providers in Community-based Integrated Systems of Care

Lenore Behar, Ph.D.
Robert Friedman, Ph.D.
Nancy Lynn, M.P.H.

The Research and Training Center
for Children's Mental Health

A Study of Service Innovations that Enhance the System of Care

Introduction

During the past two decades, there has been an increasing emphasis on the development of community-based, integrated systems of care to serve children with serious emotional disturbances and their families. Systems of care are based on the understanding that children with serious emotional disturbances have a wide variety of strengths and needs; thus, their services should be individualized, or tailored to the strengths and needs of the child and family. The individualized service plans, jointly developed by the family and the agencies involved with them, is a major underpinning of an integrated system of care. However, implementing such plans requires that a wide array of services be available to meet the individual needs of each child and family in the community system. Efforts to establish a wide array of services involve developing or expanding both traditional mental health services and non-traditional services that can be "wrapped" around the child and family. As a result, considerable attention has been devoted to individualized service planning and to creating a wide range of services. Recently, attention has been directed toward understanding the mechanisms for establishing and maintaining an array of effective and responsive services—while including other systems of care values such as providing choice for families and referring practitioners, and maximizing accountability.

To gain further knowledge about mechanisms for improving or expanding the service system, a study of nine programs across the country was designed. The plan was to focus on programs that had largely moved away from building services within one organization, such as a community mental health center. Rather, programs were identified that included creative mechanisms to:

- coordinate funding across agencies;
- establish provider networks for both formal and informal services;
- include use of data to evaluate provider performance;
- have a central role for parents in the selection of providers; and
- place emphasis on training and supervision to maintain quality.

This study was designed to understand more about these components of integrated systems of care and thus, to advance the field's understanding of provider- and system-level issues. The study was funded by the Center for Mental Health Services.

Study Design

Site Selection: Information about the study focus and methods was distributed to the state mental health directors for children's services and to other informed parties, and site nominations were solicited. Investigators stressed to both informants and sites nominated that this was not to be an evaluation of the programs, per se, but rather an opportunity to describe how each program approached provider, service delivery, evaluation, and collaboration issues. Nine sites were selected and all agreed to participate.

Additionally, sites were chosen to represent a mix of: (a) urban, small city and rural sites; (b) diverse geographic settings across the country; (c) public agency and non-profit settings, and; (d) programs based in mental health centers, schools or other child-serving agencies. The sites also varied by organizational structure and populations served, and the particular types of services offered. Table 1 summarizes key features of each site, and system approaches as related to the study issues:

Table 1
Overview of Selected Study Sites

Site/Project Name	*Population Served/ Treatment Setting*	*Infrastructure/ Provider Network*	*Funding Structure*	*Use of Data*	*Family Involvement*
1. Indiana: Dawn Project; Indianapolis	Services for youth with serious emotional disturbances and their families involved in either the juvenile justice system or the foster care system in Marion County	Non-profit organization leading collaborative effort among child welfare, special education, juvenile justice, and mental health leaders operating under the aegis of the court	Federal grant monies pooled with funds from other agencies and expended according to a case rate; Medicaid funds cover some services		Family plays a strong role in monitoring services; families interview providers, work with the case manager, and monitor progress of the child
2. Kentucky: Building Bridges of Support: One Community at a Time [Bridges Project]	Prevention and intervention strategies for youth with or at risk of developing serious emotional disturbances in rural school settings	Expanded, 3-tier, school-based intervention and prevention model, with universal, targeted and intensive tiers. School staff, Bridges personnel and parent groups provide services; Bridges personnel have offices in the schools	Operated by the Kentucky Department of Mental Health		In the intensive tier, an interagency family team designs services for the child and family; family members are key participants on this team.
3. Massachusetts: Arbour Health Systems Trauma Center, Community Services Program	Intervention in communities in Metro-Boston that have experienced psychological trauma	Community Services Program trains community providers to assist program staff. Trained provider network includes mental health professionals, school personnel and community workers, (e.g., YMCA, Boys and Girl's Club) probation officers, religious leaders	Funded by the Massachusetts Department of Mental Health		
4. Michigan (2 sites): 1. Pathways in Marquette; 2. Community Mental Health Program of Clinton, Eaton and Ingham Counties	Coordinated services for children with severe emotional disturbances in a rural area (Pathways) and the area surrounding East Lansing (Community MH Program)	Part of Michigan's public community mental health and development disabilities system.	Regional Medicaid behavioral health entities. Funding provided by Medicaid managed care program, other health insurance and state funds	CAFAS analysis allows each community mental health program to track its effectiveness and develop a data base to strengthen services	The child and family help the care coordinator/case manager develop individualized service plans
5. Nebraska: Nebraska Family Central, Region III Behavioral Health Services	Services for children with severe emotional disturbances in rural counties in central and south central Nebraska	Partnership of Region III Behavioral Health Services, Nebraska Department of Health and Human Services, and the Nebraska Department of Education. Integrated infrastructure across public agencies	Mental health, child welfare and education funds support services; Region III Behavioral Health Services manages the funds and provider network; Medicaid funds treatment services	The project utilizes MST and progress and outcomes for children are tracked through the data system to provide feedback to parents, child, team, and providers	Parents have a central decision-making role in developing individualized service plans for the child
6. New Jersey: The Children's Initiative	Services for youth with serious emotional disturbances in the State of New Jersey	The State of New Jersey contracted with a private agency to serve as the Administrative Services Organization (ASO) to authorize children to receive services, oversee the appropriateness of the plan, and ensure that providers are available and responsive	Funding sources include agencies within the Health and Human Services Department (but not Education) and Medicaid	The ASO tracks service utilization , needs and costs. Standardized assessment measures and protocols are also utilized.	Expected increase in family and child participation in decision-making

Site/Project Name	*Population Served/ Treatment Setting*	*Infrastructure/ Provider Network*	*Funding Structure*	*Use of Data*	*Family Involvement*
7. New York: Kids Oneida; Oneida County	Services for children with serious emotional disturbances in Oneida County who are at risk for out-of-home placement and/or to shorten the time in such placements	Jointly established by the New York State Office of Mental Health, the New York State Department of Health, and Oneida County; a not-for-profit care management entity operates the program; children are accepted into the program by the Oneida County Committee on Appropriate Placement or the Oneida County Department of Social Services Placement Committee	Funded through a blend of Medicaid, mental health and social services funds, including a bundled case payment fee from Medicaid and a case payment from Oneida County Department of Social Services. Flexible funds are also available for family strengths and needs.		Individualized plans of care are developed in partnership with the child and parent(s), other relevant agencies or providers, and the Kids Oneida individual service coordinator
8. Wisconsin: Wraparound Milwaukee	Services for children with serious emotional disturbances and their families in Milwaukee County who are at risk of entering residential care or psychiatric hospitalization	Part of the Milwaukee Community Mental Health Center. Collaboration among child welfare, juvenile justice, mental health and education	Funds are pooled from child welfare and juvenile justice, along with a capitation payment from Medicaid	A data system is used to manage services and funding, with output on quality assurance/quality improvement and client outcomes	The child and family team designs the service plan, and a strong parent organization oversees service delivery and program management

Eight of the nine sites provide direct assessment services and intervention/treatment services to children and their families Within this group, the Kentucky sites' approach was unique insofar as the majority of their services were delivered through the school system and in the schools. The ninth site, in Massachusetts, was selected because it had established a provider network to deliver services to communities in which traumatic events had occurred, rather than to individual clients.

Method: The study was conducted between September 2002 and June 2003. A case study method was used**,** which involved two-day visits to each community by at least two experienced mental health professionals. Investigators reviewed written documents and data, and interviewed key stakeholders. Depending on the site, the stakeholders included individual and agency providers, parents and children, policy-makers and administrators, and the leadership from related systems (e.g., child welfare, the schools, and juvenile justice). The Massachusetts site also included stakeholders such as city, state and federal elected officials and representatives from the school systems and law enforcement. The Kentucky site included interviews with school personnel at multiple levels.

In order to describe innovations in coordinated funding, provider networks, performance data, family role and provider training and supervision, key elements were identified for site-level examination. These included, depending on the site:

- history and development of the project, especially how the provider system evolved;
- which providers of services become a part of the system;
- how or if children are matched to providers;
- role of the family in selecting the provider and designing the services;
- training for the providers;
- supervision of providers;
- monitoring of service delivery and system performance;
- use of evidence-based practices;
- accountability mechanisms;
- financing of services; and
- types of outcomes measured, procedures for measuring them, and use of the data.

Analyses of the findings and recommendations to the field are based on an integration of the above eleven elements across the nine sites. Extensive field notes were taken on each visit, and written documents were gathered and reviewed. The investigators identified common themes in the sites that were visited. They shared observations with each site, asked questions for clarification, and checked the accuracy of information.

Findings: Central Issues And Common Factors

The study of the sites indicated that they have many strengths, and much was learned from their work. Universally, these sites were found to have developed extensive networks of providers that are managed well. The providers in the networks of the eight treatment sites include those who provide traditional treatment services and those who provide an array of non-traditional wraparound services (e.g., mentoring, therapeutic recreation, and therapeutic aide services, etc.). The providers in the network of the community-focussed Massachusetts project had all received training in trauma psychology, and appeared to follow the protocol of the project for all interventions. In all sites studied, there was evidence that the providers have brought expanded cultural diversity to the system. It was apparent that these providers have remained in the system because of their perceived capacity to deliver good outcomes and because the families considered them to be good and responsive providers.

The network of services in the Bridges Project in Kentucky merits separate description, as it includes an array of services within the schools. For this site, the expanded provider network is school-based and includes principals, teachers, teachers' aides, and school counselors. In each school system involved in the Bridges Project, there were three levels of intervention: 1) school-wide positive mental health interventions for all children, focused on helping them to develop strengths; 2) classroom-based interventions, provided by the teachers with coaching from mental health professionals for children with emerging difficulties; and 3) individual or group treatment for children with diagnosed disorders. Parents were involved in all three levels, with a defined role of support for other parents with children in levels two and three.

Similarly, the Community Services Program in Massachusetts operates within both the public and parochial school systems in Metro Boston, as well as in community sites. Through intensive training to all the school principals, most of the school counselors and many teachers, the program appeared to have prepared the schools well to handle emergencies and to call for support from the program, as needed.

*Collaborative Service Planning***:** Each of the eight treatment sites serves as a central point for referral and service planning for children with serious emotional and behavioral disorders. In Wraparound Milwaukee and the two programs in Michigan, an internal management team determines entrance into the program, but the other agencies seemed pleased with this referral approach and reported that they believe that the "right" children were provided the "right" services. In the Dawn Project, all referrals come through the court for children in the protective services, foster care or juvenile justice systems. For the most part, the sister agencies reported satisfaction with this approach. In Kentucky, decisions about entry into the classroom-based interventions and individual services were made jointly by the team of school and mental health personnel. In Nebraska Family Central, New Jersey, and Kids Oneida, interagency teams comprised of agency providers and parents determine who receives services from the system. Except for the Kentucky Bridges Project and Nebraska Family Central, the weakest link in collaborative planning appeared to be the education system.

In all the programs, regardless of how the decisions were made about entry into the program, the service plans were developed jointly by the relevant agencies, and in all sites parents were found to have a key role in the design of services. Investigators found that, overall, strengths-based assessments served as the foundation for service planning. The service plans reviewed were individualized and based on the strengths and needs of the child and family. In all settings, effective care coordination/case management appeared central to the oversight of the service plan with the goal of ensuring that the plan is being implemented, children are getting services, progress is being made, and families are satisfied with the services. Service plan revisions were the responsibility of the care coordinators/case managers.

In a few sites, service planning did not include some of the actual providers, because plans for traditional services are referred to Medicaid providers, who chose not to participate in team planning meetings. Although the program leadership at these sites stated that they would welcome Medicaid provider participation, they felt that—as a lesser alternative—the quality of services was adequately maintained through telephone contact and written reports by the case managers. This was not perceived as an issue of failed communication, but rather of finding alternatives to the providers' presence at team meetings. In other sites, Medicaid providers did participate in service planning. Across sites, any participant in service planning can ask for a review of the plan or a change in the plan. Family members and family organizations reported that they placed considerable value on these functions, felt valued as members of the team, and saw that their input regarding the performance of providers as important.

Building Service Capacity: A wide array of services is essential to make the concept of individualized service planning a reality. In all sites, the service plans reviewed included both traditional services and non-traditional services (i.e., services not usually considered as part of a health benefits package). The flexibility of funds for these programs make this mix possible, as does the availability of providers from whom to purchase these services. In Kentucky, these services are created within the school setting primarily, with only those children in need of intensive clinical services being referred out. In the two Michigan sites and Kids Oneida, many, but not all of the services, were built within community mental health programs. In the other sites, services were provided through contracts with individual providers or provider groups. All of the sites purchased non-traditional services, which might include mentoring, therapeutic recreation, therapeutic aides, respite care, training in skills to improve self-esteem (e.g., music lessons), or vocational training. Typically, these services were purchased on a fee-for-service basis from providers, with agreed-upon rates for units of service, and no guaranteed volume of service. The degree to which particular providers were used was found to be dependent upon the need for the type of service they offered, as determined by individual child and family treatment teams, and the provider choice of the families.

There are several examples of programs that have begun to identify the infrastructure necessary to provide a wide array of services that blend family choice, quality assurance and increased accountability. Their efforts suggest that the development of a large, diverse, and accountable provider network may be an extremely effective way of providing services, and including systems-of-care values such as family-driven services and cultural competence. Examples from the sites include:

- Wraparound Milwaukee has created over 80 different services through contracts with 240 providers, both individual and organizational, in order to offer families genuine choice. To ensure accountability, the contractors have agreed to participate in ongoing quality assurance/quality improvement studies. Investigators found that the project staff used an extensive data system to monitor progress and outcomes by child, by provider and by cost. Families also provide feedback on their experiences with individual providers.
- The Dawn Project in Indianapolis has developed a network of over 500 providers, and has purposefully recruited providers from the minority community. They report that families can suggest providers that they know. There are mechanisms in place for families to interview providers and select those that fit best with their goals and needs, provide feedback on individual providers, and ask to have providers replaced if they are dissatisfied with their services or service experiences.
- Kids Oneida has developed an array of 36 services. They endorsed the availability of flexible funds as giving them the capacity to create new, individualized services as needed.
- New Jersey's State Department of Human Services described ambitious efforts to develop systems of care statewide, integrating child-serving agencies and investing in strong family organizations as partners in this endeavor. They have invested substantially in an independent management structure and are following a carefully designed implementation process. These plans imply recognition that having a range of providers for each type of service is advantageous.
- Nebraska Family Central has focused on developing evidence-based practices within their provider network and has funded training in MST for professionals. Training through the MST program in Charleston, SC includes fidelity checks to ensure that the integrity of services are consistent with the MST model. This is integrated with their treatment team planning process.

- The Massachusetts Community Services Program provides a community-level intervention, but also identifies children and families that are not recovering from trauma within the wide band of normal responses. Individuals who need more intensive services are referred to the service network; they are accompanied by the program staff or network providers to ensure that they are tightly connected to this next level of service.

Financing the Service Capacity: Most of the eight treatment sites have kept a large part of their money flexible and use it to expand the provider network and the available service array, and to fund individualized service plans. These systems were found to be characterized by medium to large provider networks and service arrays, extensive flexible funding, opportunity for families to choose their services and providers, and a strong system of feedback on provider performance. There were two exceptions to this approach, in the two most rural sites studied: (a) Pathways in Marquette, located in the Upper Peninsula of Michigan, primarily uses their flexible funds internally, as the extensiveness of their provider network is limited by availability; and (b) The Bridges Project, which operates in the mountains and hollows of eastern Kentucky has, due to the scarcity of providers, developed the school system as the provider network.

To some extent, all eight treatment programs have blended funds from other agencies to pay for the service systems. In Wraparound Milwaukee, funds are aggregated locally, along with a major portion of funding from the county. The Medicaid funds in Wraparound Milwaukee come directly from the state agency at an established case rate. In the Dawn Project, the two projects in Michigan, Nebraska Family Central, and Kids Oneida, the funds from other agencies are brought together locally to fund services; each agency has an established amount they contribute not tied to the referrals made.

The Medicaid funds were found to flow through the local mental health agency on a fee-for-service basis in all but the Dawn Project. In New Jersey, agency funds are pooled at the state level and are used primarily to support the infrastructure of the program and services not covered by Medicaid; the Medicaid funds are billed directly from the providers to the state Medicaid agency, as fee-for-service. In Kentucky, much of the contribution from the schools is in the form of personnel and space. Medicaid is accessed on a fee-for-service basis. As noted above, the Massachusetts program is fully funded by the Massachusetts Department of Mental Health and is not fee-based.

In each of the eight treatment programs, the amount contributed across agencies was not equal; however, the unevenness did not seem to be an issue. Each program used Medicaid slightly differently. Wraparound Milwaukee and Kids Oneida provided examples where the Medicaid funds have been combined with other funds in a pool. In the two programs in Michigan and Nebraska Family Central, it was reported that Medicaid funding works reasonably well for the programs, although they could identify areas for improvement. In New Jersey, the plan has been to expand the kinds of services that are reimbursable by Medicaid and to increase the rates for many services; providers bill Medicaid directly. The intent is to modify Medicaid to support a wider range of services and providers. The Dawn Project and Kentucky Bridges have the least support from Medicaid, as, in both cases, only those children who receive direct services or case management from the mental health center are eligible for Medicaid funding. These two programs do not compromise services to the children, but rather pay for them from other funds. It was felt that improvements in their Medicaid programs would allow them to use their funds for other purposes, rather than supporting treatment costs. The Massachusetts Community Services Program does not access Medicaid reimbursement or funding.

Role of Parents and Parent Organizations: Parents or parent organizations were found to have established roles in all of the programs. In all the sites, parents were considered equal members of the service planning teams, and care coordinators/case managers involved family members in the implementation of services, review of services and reconsideration of services. In Wraparound Milwaukee, the Dawn Project, and Kids Oneida, parents were viewed as the "purchasers" of services; the parents and the providers both endorsed this viewpoint. Parents "hire" and "fire" providers, and the provider's life with the program is dependent upon the appraisals of parents. In all the programs, provider training, by parents, was reported to be a respected element. Support for parent groups also was evident in these sites. Table 2 shows parent roles across the sites reviewed.

Table 2
Family Roles Across Study Sites

	Family Role				
Site	*Equal member of service planning team*	*Parents train providers*	*Parent orgs provide services*	*Parents viewed as "purchasers" of services*	*Financial support for Parent organizations*
Michigan; Pathways in Marquette	X	X			X
New Jersey's State Department of Human Services	X	X			X
New York: Kids Oneida	X	X	X	X	X
Nebraska Family Central	X	X	X		X
Dawn Project in Indianapolis	X	X	X	X	X
Wraparound Milwaukee	X	X	X	X	X
Kentucky: Building Bridges	X	X	X		X
Michigan: Community Mental Health Center	X	X			X
Massachusetts Community Services Program	X	X			

In some sites, such as the Dawn Project, Kids Oneida, the Kentucky Bridges Project, Nebraska Family Central, and Wraparound Milwaukee, parent organizations provide services, such as parent support groups and parent education services, and members accompany family members to service planning meetings, to court and to school planning meetings (IEPs). These organizations provide parent-to-parent support and advocacy to help parents negotiate the system and take an active role in their child's treatment. Family organizations were found to incorporate culturally diverse perspectives to help guide the programs. In the Kentucky Bridges Project, the parents' organization which operates within the schools was central to the services provided which included mentoring, counseling and a broad range of supports for families.

Most of the sites have committed to financial support for the parent organizations. New Jersey has provided funding statewide to parent organizations from the state office. The parent organizations appeared to have considerable potential as advocates within the programs for quality services for children and families, and externally as advocates for the programs on issues such as continued funding and program expansion. And in all cases, parent organizations were reported to be very important to caregivers as their children enter the system.

*Training and Supervision of Providers***:** All the programs demonstrated a focus on ongoing training and supervision of service providers to ensure fidelity to systems-of-care principles and to quality services. Good relationships were evident with providers and provider agencies, as evidenced by their participation in training to gain/maintain understanding of program philosophy and service emphasis. All of the programs have focused on re-training existing providers and suggesting alternatives to traditional modalities of service provision. Investigators found a large number of non-traditional service providers who offer mentoring, supervision activities for clients, advocacy for clients and families in school and in court, and other interventions as the needs of the clients dictate. Of note were contracts for services provided by neighborhood organizations or individuals within neighborhoods, fostering services that are responsive to local ethnic and racial groups. The strong link evident between service providers and care coordinators/case managers has clearly informed the programs and supported approval of non-traditional interventions.

The school-based Kentucky Bridges Project's training program is focused on school personnel, including principals, teachers, aides, and counselors. School personnel serve as "providers," except in the case of children with the most serious problems. The school personnel have received extensive training in contemporary mental health concepts to be applied universally throughout the schools. They have also been trained in classroom behavioral management techniques to promote support of individual children with problems within the context of the whole classroom.

The Massachusetts Community Services Program's approach was designed to ensure that providers conform to a evidence-based protocol. The program's rigorous training curriculum has two levels: 1) introductory training, which equips providers with skills necessary to work as part of the team; and 2) advanced training, which consists of team-leader training. Annual re-training is required. The program staff provide ongoing supervision of the providers in the network.

Investigators found that Wraparound Milwaukee provided an outstanding example for facilitating a change in focus among providers. This program has been very successful working with traditional, residential programs to broaden the array of services they provide, help shift beliefs about how to provide services to those with intensive needs and deliver services outside of the residential setting. Wraparound Milwaukee staff directly supervise the staff of contracted agencies to ensure model constancy and quality services.

New Jersey started a statewide rollout of a systems-of-care approach with approximately half the counties in the state. Investigators found a comprehensive plan for training, at all levels of providers, and for most, if not all, aspects of services. Training covers the systems-of-care philosophy, along with clinical and administrative issues (e.g., data input, use of the information system, forms, etc.). Program staff have consulted with programs with successfully implemented systems of care, primarily Wraparound Milwaukee and the Dawn Project, for advice, training, and supervision related to service delivery. Videoconferencing is used when trainers/supervisors from Wraparound Milwaukee and the Dawn Project are not on-site.

In the Dawn Project and Wraparound Milwaukee, their states support training for replication. In these states, the mental health state agency has provided funding for the programs to conduct training across the state to sites that are interested and ready to replicate these services.

*Use of Data to Manage the System***:** All of the programs have established mechanisms to collect data and use it for project management, indicating that this may be a very important feature of good programming. In particular, the Dawn Project, Nebraska Family Central, Kids Oneida, and Wraparound Milwaukee demonstrated success in utilizing a well-developed management information system to support management decisions about funding provider contracting, as well as for quality assurance/quality improvement studies, service utilization studies and outcome studies. The Children's Initiative in New Jersey's system was not complete at the time of the study, but substantial plans were in progress and substantial dollars had been committed, indicating the state's commitment to using data to manage the system.

All of these sites have invested substantially in information systems and express a high priority on using these systems to collect meaningful data. It was evident that data collected were used as management tools and as tools to convey program progress and success. The reliance on quality information systems that serve many purposes seems essential, and these programs represent a new generation of management in this area. Importantly, all programs had staff dedicated to program evaluation activities.

Additionally, the Dawn Project, Nebraska Family Central, the Massachusetts Community Services Program and Kids Oneida have contracted with universities to obtain independent assessments of their programs. The two programs in Michigan are part of a state-university partnership that provides program evaluation.

In terms of data systems, Michigan's programs deserve special attention Michigan's programs were given priority during site selection because the state's child mental health office had introduced outcomes-driven program evaluation conducted jointly with university faculty. Each child receiving services at the local community mental health program is regularly assessed using a well-validated measure of child progress and outcome (the Child and Adolescent Functional Assessment Scale; CAFAS, Hodges, 2000), and data are submitted to the state's office of Mental Health Services to Children and Families. Scores are aggregated for each community mental health center, producing an overall picture of progress and outcomes by community programs. The two sites in Michigan selected for study had shown the best progress and outcomes, statewide. Discussions with these program informants indicated that they use their data for internal assessment, to understand when different approaches with a client might be needed, and to drive their service system. Data also are used with partner agencies to review client progress. Although both of these programs were somewhat more traditional in service provision than the other six service programs studied, their approach to

clients and services is noteworthy. From the top leadership of the program to the direct service staff, there was a clear commitment to quality, to intensive outreach to clients, to "going the extra mile" to engage clients and their families to provide individualized services.

Specific Areas of Concern: Although each site was exemplary overall, some areas for improvement were evident. In some sites, the program leaders were aware of these issues and were seeking to remedy them. In other sites, the observations of the reviewers provided new information. Areas of concern, aggregated across sites, included:

- limited psychiatric services and therefore limited capacity for medical diagnoses and the use of medication;
- a small number of providers for certain services, which meant an over-reliance on these providers;
- limited access to Medicaid reimbursement for services, primarily because of limitations in the state's Medicaid Plan;
- limited participation of the school systems in service planning;
- limited assessment of the quality of services, with feedback to the providers so that they can correct problems, if present; and
- absence of comparison data with other sites or with other types of services.

Although these concerns existed in some of the sites, in other sites most of these concerns were nonexistent, indicating the strengths of the programs. Thus, these six concerns seem to reflect the most difficult barriers—barriers that even successful programs are struggling to overcome.

Summary

This study's purpose was to gain understanding of the mechanisms for expanding or improving a service network, with a primary focus on how the use of providers was evolving. Nine sites were selected for the study, based on nominations from state mental health leaders and other knowledgeable persons. Overall, these programs were outstanding and they provided examples of "cutting edge," quality work. The purpose of the study was not to evaluate these programs but to learn from them.

Eight treatment programs and one community services program participated in this study and although each had a somewhat different approach to service provision, there were similarities that are worth noting. In all eight of the treatment programs, we found a high priority on individualized service plans. All nine programs focused on treating each child and family with care and respect. The role defined for families in these programs was exceptional—in determining service plans, selecting providers, evaluating providers, and providing support for other families. Respect for culture and ethnicity was also apparent. Each of these programs had developed strong partnerships with their communities and community agencies. In the eight treatment sites, the child-serving agencies have come together to plan services for children and to share in the funding of services. Partner community agencies provided in-kind and monetary contributions to the program and shared the responsibilities for the program. All the programs used data to manage their systems and they were open to sharing information about their programs with their communities. The attitudes and actions of both the program leaders and the staff reflected commitment to and respect for their clients. All in all, these programs have put into practice the spirit, principles and philosophy of systems of care.

Other, newer contributions from the sites include:

- The concept of service array has been broadened by the more extensive use of non-traditional services;
- If providers of needed non-traditional, wraparound services were not available in the community, the programs have trained them in both program philosophy and service provision;
- The usual way of expanding services, that is, hiring more staff, has been replaced by the more flexible approach of purchasing from a wide group of providers, many of whom were members of the community;
- Intensive training and supervision are provided to ensure that providers adhere to the program philosophy and approach;
- Parents evaluate the effectiveness of the services, as well as their satisfaction with the services;

- The programs purchase outcomes rather than just services;
- They use good business practices to develop "performance-based" contracts; and
- They use data to drive their systems.

The programs studied also offer information about directions for the future, which includes a continuing need to focus on the following areas for improvements:

- Relationships across agencies, especially with the schools;
- Funding of services, especially Medicaid;
- Expanding the provider networks, especially for non-traditional services; and
- Increasing evaluations of the quality, effectiveness, and impact of services.

All in all, the programs studied represent cutting-edge approaches to children, families and communities. They provide ideas about promising new directions for services.

Reference

Hodges, K. (2000). *Child and Adolescent Functional Assessment Scale* (3rd ed.). Ypsilanti, MI: Eastern Michigan University.

The Research and Training Center for Children's Mental Health
Department of Child and Family Studies
Louis de la Parte Florida Mental Health Institute
University of South Florida
13301 Bruce B. Downs Blvd.
Tampa, FL 33612-3807
(813) 974-4661 Fax: (813) 974-6257